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ABSTRACT

The 1970 Alaska state plan for construction of facilities for the mentally retarded is discussed. State agency organization charts, methods of administration, program goals and policies, an election district map showing catchment areas and future reservations, an explanation of inventories, and a survey of need and testing of areas comprise the plan. An appendix covers characteristics of the mentally handicapped, statutes and codes, progress made in implementing the plan, and guidelines for the future. (CJ)

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ALASKA/STATE PLAN FOR--1970

CONSTRUCTION

OF

FACILITIES FOR THE MENTALLY

RETARDED

EDO 47481

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Designation of State Agency

The 1964 session of the Legislature of the State of Alaska amended the Alaska Hospital and Medical Facilities Survey and Construction Act (Title 18, Chapter 20, Article 2) to name the Department of Health and Welfare [Sec. 18.20.310(1)] as the sole agency for the administration of the State Plan as required by the Federal Act. (1964 session laws, Chap. 63, Sec. 4, 18.20.140 and Sec. 7, 18.20.310(2)).

The Health and Welfare Facilities Coordinator has been designated by the Commissioner of Health and Welfare to prepare the State Plan for the construction of facilities for the mentally retarded. The State Plan is prepared in accordance with the 1964 amendment of Alaska Law Sec. 18.20.130 (Sec. 3, Chap. 63), and the 1963 amendments.

GOVERNOR'S REVIEW

This Plan has been submitted to the Governor for his review, and his comments, which are attached. The State Agency assures that any amendments to this Plan, as well as projections or other periodic reports required under the program will also be submitted for the Governor's review, and comments, if any, will accompany the amendments or other required program materials when they are submitted to the Rehabilitation Services Administration, Mental Retardation Community Facilities Construction, Department of Health, Education and Welfare.

MEMORANDUM

State of Alaska
OFFICE OF THE GOVERNOR

TO: Lowell W. Deerts, Coordinator
Health Facilities Development
Office of Comprehensive Planning

DATE: July 21, 1970

FROM: Keith Hart
State-Federal Coordinator
Division of Planning and Research

SUBJECT: A-95 Clearinghouse Review: Mental Retardation Facilities Construction (State Plan)

This office has reviewed the subject plan. The plan appears to be consistent with state planning goals and objectives.

This memorandum will satisfy the requirements of Bureau of the Budget Circular Number A-95. A copy of notification of intent to apply for federal assistance is attached for your records.

Attachment

Attachment

NOTIFICATION OF INTENT TO APPLY FOR FEDERAL ASSISTANCE

1. Name and address of applicant organization

Coordinator
Health Facilities Development
Office of Comprehensive Planning
Alaska Department of Health & Welfare
Pouch H, Juneau, Alaska 99811

2. Geographic location of proposed project or activity (location should be as specific as possible by geographic, area boundaries)

State of Alaska

3. Brief description of proposed facility name, purpose, scope, anticipated cost, beneficiaries, or other characteristics which would assist the clearinghouse review or comment (for EIS/EIR the proposed scope should be an outline)

See Construction Plan Attached.

4. Federal agency and organizational element to which application will be sent

Department of Health Education & Welfare

Social Rehabilitation Facilities Construction

5. Estimated date when application will be submitted

Not Applicable

Name and title of applicant person

Coordinator
Health Facilities Development
Office of Comprehensive Planning
Alaska Department of Health & Welfare
Pouch H, Juneau, Alaska 99811

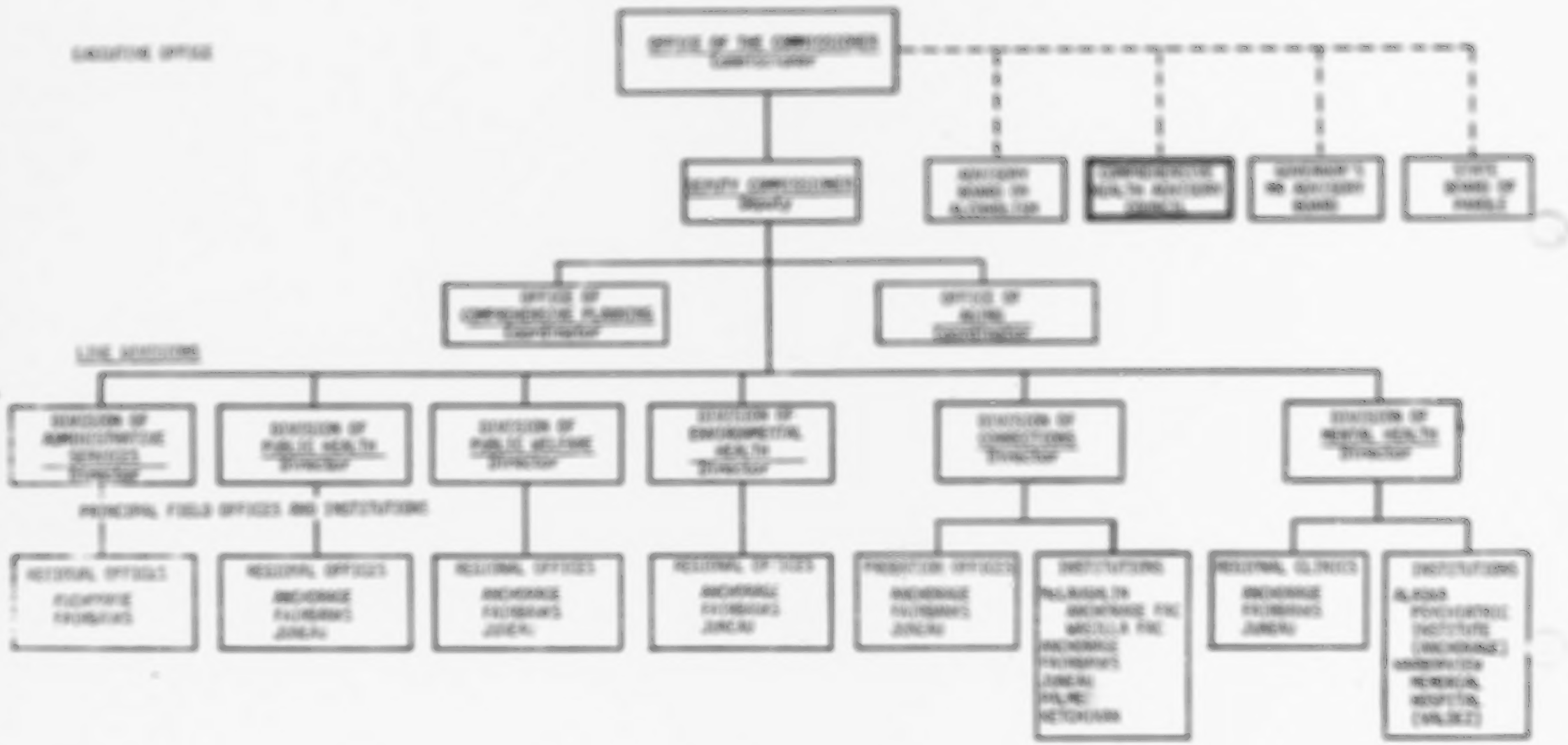
Signature of official

Date:
June 16, 1970

Copy to: 2 ea State Clearinghouse — Regional or Metropolitan Clearinghouse — State Central Office

STATE AGENCY RELOCATION UNIT

Two organization charts are made a part of this project. The first shows the general overall relationships within the Department of Health and Welfare, as well as the advisory relationships with the Comprehensive Health Advisory Council (CHAC) and other boards. The second shows the administrative responsibility of Facilities Development, an entity of the Office of Comprehensive Planning. The Comprehensive Health Advisory Council, functions as the Mental Health Advisory Council.

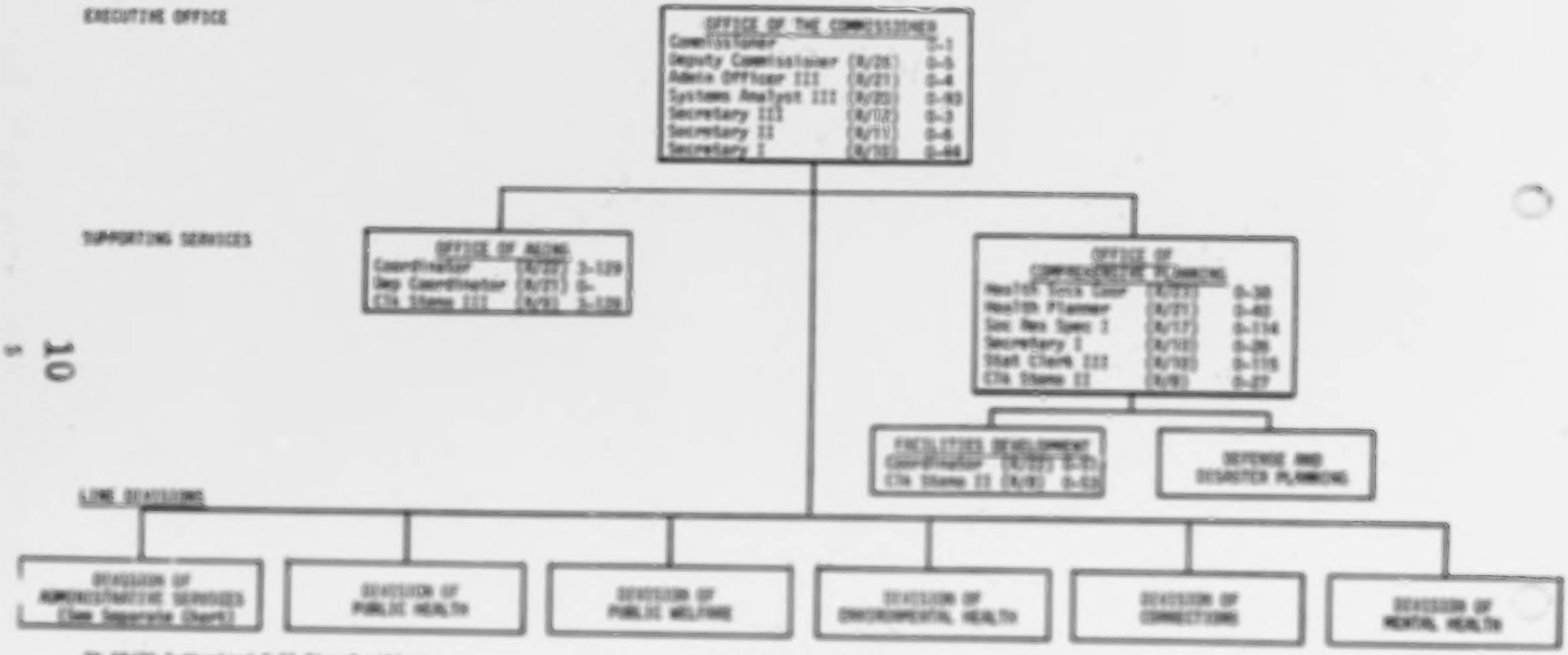

EXECUTIVE OFFICE
LINE AGENCIES
PRINCIPAL FIELD OFFICES AND INSTITUTIONS

STATE OF ALASKA

DEPARTMENT OF HEALTH AND WELFARE
GENERAL ADMINISTRATION STAFFING CHART
(BASED ON GOVERNOR'S FY 70/71 BUDGET ALLOWANCE)

EXECUTIVE OFFICE

SUPPORTING SERVICES


OFFICE OF THE COMMISSIONER
Commissioner
Deputy Commissioner (R/25)
Admin Officer III (R/21)
Systems Analyst III (R/23)
Secretary III (R/12)
Secretary II (R/11)
Secretary I (R/10)
OFFICE OF AGING
Coordinator (R/22) S-129
Dep Coordinator (R/21) S-
Clk Stenno III (R/9) S-126
OFFICE OF COMPREHENSIVE PLANNING
Health Stats Coor (R/23) S-38
Health Planner (R/21) S-40
Soc Res Spec I (R/17) S-114
Secretary I (R/10) S-26
Stat Clerk III (R/10) S-115
Clk Stenno II (R/8) S-27
FACILITIES DEVELOPMENT COORDINATOR (R/22) S-
Clk Stenno II (R/8) S-
DEFENSE AND DISASTER PLANNING
LINE STATIONS
DIVISION OF ADMINISTRATIVE SERVICES (See Separate Chart)
DIVISION OF PUBLIC HEALTH
DIVISION OF PUBLIC WELFARE
DIVISION OF ENVIRONMENTAL HEALTH
DIVISION OF CORRECTIONS
DIVISION OF MENTAL HEALTH

FY 69/70 Authorized Full Time Positions

Commissioner's Office	7
Div. of Admin Svcs	85 - Includes 2 transfer gains,
Comprehensive Planning	6 i.e., Statistician, Mental Health;
Aging	3 Accounting Technician, P. O.]
	101

FY 70/71 New Positions

Div. of Administrative Services	6 Full Time
	1 Part Time
	6 1/2

(See Division of Administrative Services Chart for justification.

ADVISORY COUNCIL LISTING

Chapter 122, SLA 1967, created a Comprehensive Health Advisory Council. Sec. 18.05.031 Comprehensive Health Advisory Council.

(a) There is created a Comprehensive Health Advisory Council which shall consist of governmental and nongovernmental members.

(b) The Council shall include 11 nongovernmental members, eight of whom shall be representatives of nongovernmental agencies which are concerned with health care services.

(1) Nongovernmental members are appointed by the governor subject to confirmation by a majority of the members of the legislature in joint session. Four members shall serve initial terms of two years, four members initial terms of three years, and three members initial terms of four years. Initial terms date from February 1 before appointment. Thereafter, terms of office are four years, unless the appointment is for the remainder of an unexpired term. Each member holds office at the pleasure of the governor notwithstanding the member's term.

(2) Nongovernmental members may carry out their duties on the Council after appointment but before confirmation or rejection by the legislature.

(3) Nongovernmental members receive no salary but are entitled to per diem and travel expenses authorized by law for state boards. Nongovernmental members may receive travel expenses and per diem in connection with the exercise of their duties as Council Members before their confirmation or rejection by the legislature.

(c) The Council shall include four governmental members: one from the Department of Health and Welfare; one from the Department of Administration; one from a health agency of a local government unit; and the Commissioner of Health and Welfare. The governmental members, other than the Commissioner of Health and Welfare, are appointed by the governor. The Commissioner of Health and Welfare shall act as Chairman of the Council, and his Department shall administer the comprehensive state health service plan.

(d) The governor shall appoint two advisors to the Council; one of whom shall be from the Department of Labor and one of whom shall be from the Department of Education who shall represent education and vocational rehabilitation.

(e) Additional Members may be appointed under this section by the governor in compliance with federal law. The terms of the additional members shall be four years, or in case of conflict with federal law, that required by federal law.

POWERS AND DUTIES: The Comprehensive Health Advisory Council shall:

(1) Advise and consult with the Commissioner of Health and Welfare regarding:

(A) programs for the construction of health facilities for the state and its political subdivisions;

(B) the development of rules, regulations, and standards for the operation of health facilities;

(C) the development of a comprehensive state health service plan, to be reviewed at least annually, and to be submitted to the Surgeon General of the United States for his approval;

(2) Request the cooperation of governmental and nongovernmental agencies in planning and developing programs relating to the rehabilitation, education, employment, health and welfare of patients in health facilities;

(3) Exercise the additional powers and perform the duties which are necessary to comply with appropriate federal programs.

A concerted effort has been made to appoint to the Comprehensive Health Advisory Council representatives from as many geographical areas as possible. Varied organizational interests have also been pursued. The huge distances between members' homes have caused each meeting to become quite expensive. Therefore, the Council meets only once a year for the purpose of Health and Welfare Facilities Planning. However, if urgent, the Facilities Planning function can be done during other meetings of the CHAC.

The Council, in addition to the statutory duties and responsibilities, has been delegated authority by the Commissioner of Health and Welfare to recommend construction priorities among eligible agencies when there are more applicants than can be assisted with available funds.

Following is a list of members of the CHAC, enumerated in the three groupings requested:

1. Representatives of Governmental Agencies

Name and Occupation	Appointment Expires
J.V. Batts, Chairman, Non-voting Commissioner Department of Health and Welfare Pouch H, Juneau, Alaska 99811	Non-expiring
Thomas E. Dimond Commissioner Department of Administration Pouch C, Juneau, Alaska 99811	Non-expiring
Glen Wilcox Coordinator Department of Health and Welfare Office of Alcoholism Pouch H, Juneau, Alaska 99811	Non-expiring
Patricia Rogers, PHN Regional Nursing Supervisor Department of Health and Welfare 4014 Bayshore Avenue Anchorage, Alaska 99501	February 1, 1971
Hal Perrenoud Commissioner Department of Public Safety Pouch N, Juneau, Alaska 99811	February 1, 1971
Thomas J. Moore, Advisor, Non-voting Commissioner Department of Labor 7-700 Gold Street, Juneau, Alaska 99811	Non-expiring

Name and Occupation	Appointment Expires
Carroll Craft, Advisor, Non-voting Director Division of Vocational Rehabilitation Department of Education Fourth F, Juneau, Alaska 99801	Non-expiring

2. Representatives of Non-Governmental Organizations

Rev. William T. Hearon Minister Member of Alaska Mental Health Association 3035 First Street Fairbanks, Alaska 99701	February 1, 1971
Mrs. Alice Scott, RN School Nurse Member of Alaska Board of Nursing 1650 E. 27th Avenue Anchorage, Alaska 99501	February 1, 1971
Lloyd Sutton Coordinator Alaska Federation of Native Health Rights 7500 E. Twentieth Avenue Anchorage, Alaska 99501	February 1, 1971
Elsie Ostrosmo Member Juneau Association for Retarded Children P.O. 1, Box 1472 Juneau, Alaska 99801	February 1, 1971
Elsie Hawana Blue, RN Executive Secretary Alaska State Hospital Association 6831 Shatwood Avenue Anchorage, Alaska 99504	February 1, 1971
Joseph M. Bikor, MD Physician Member of Alaska State Medical Association 522 Fifth Street Fairbanks, Alaska 99701	February 1, 1971
D.L. Steeley, DMD Dentist Member of Alaska Dental Association 335 Second Co-op Building Fairbanks, Alaska 99701	February 1, 1971

Name and Occupation	Appointment Expires
Robert Wilson, MD Physician Alaska State Medical Association 718 K. Street Anchorage, Alaska 99501	February 1, 1971

3. Representatives of Consumers

Don Davey Executive Director Alaska Municipal League 203 Municipal Building Juneau, Alaska 99801	February 1, 1976
Richard Bellon Banker First National Bank of Anchorage 2364 Lawsuit Drive Anchorage, Alaska 99501	February 1, 1975
Don Craddick Lawyer 421 Coleman Drive Juneau, Alaska 99801	February 1, 1975
Mrs. Lucile (Teddy) Hunter Secretary P.O. Box 36 Juneau, Alaska 99801	February 1, 1971
Leo Rhode Businessman P.O. Box 610 Nome, Alaska 99615	February 1, 1976
Wilma Rhodes Manager - Rhodes Apartments 336 East 3rd Street Juneau, Alaska 99801	February 1, 1971
Sarah Schieffere Housewife 1101 Endich Street Fairbanks, Alaska 99701	February 1, 1975
Ellis B. Vermeer Postmaster - Entrepreneur Koyukuk, Alaska 99754	February 1, 1976
P.C. McCormick III Businessman P.O. Box 762 Wrangell, Alaska 99929	February 1, 1971

Name and Occupation	Appointment Expires
[redacted] Magistrate Barrow, Alaska 99723	February 1, 1974
[redacted] Councilman P.O. Box 111 Barrow, Alaska 99777	February 1, 1971

Procedure of Publicizing the State Plan

At least Thirty (30) days prior to the submission of the State Plan or any modification thereof to the Surgeon General, the Alaska State Department of Health and Welfare shall publish in newspapers having general circulation throughout the State a general description of the proposed plan or any such modifications.

A Public Hearing will be held concerning the contents of the State Plan if requested.

The State Plan will be available for examination and comments by interested persons prior to submission to the Surgeon General.

One approved copy of the State Plan for each fiscal year will be available at all times in the State agency for public examination.

Project Construction Schedules

The development of the State Plan reflects priorities which determine the projects for which fund requests will be made. Construction schedules are prepared according to the availability of matching funds, the priority of the project, and the approval of the State Plan by the Comprehensive Health Advisory Council and the Surgeon General. The schedule will list the projects proposed for the next fiscal year and shall be submitted prior to the submission of the first construction application in each fiscal year.

Deadline for Submission of Applications

The cut-off date for filing project applications for any fiscal year shall be the first day of October.

Standards of Construction and Equipment

1. The general standards of construction and equipment shall not be less than the minimum standards of the authority in which the facility is proposed or the standards prescribed by the Surgeon General and as set forth in Sec. 54.113 (Appendix A - General Standards of Construction and Equipment) of Part 54, or as it may be amended or revised in the future, whichever is the higher.

2. Equipment means those items which are necessary for the functioning of the facility, and which are considered as depreciable and as having a life of not less than five years. Not included are the items of current operating expense such as food, fuel, drugs, paper, printed forms and soap.

Inspections Procedures

1. When a request for payment of an installment is made, the Department of Health and Welfare will cause to be made an inspection of the project to determine that services have been rendered, work has been performed, and purchases have been made as claimed by the applicant and in accordance with the approved project application.

2. The Department of Health and Welfare will make such additional inspections as are deemed necessary.

3. Reports of each inspection will be retained in the files of the Department of Health and Welfare.

4. Files will be maintained on all correspondence incident to inspections of a project.

Construction Payments

1. Requests for construction payments shall be submitted by applicants to the Department of Health and Welfare at the times prescribed by Section 54.115 of Part 54, PHS Regulations for Grants for Construction of Facilities for the Mentally Retarded.

3. The Department of Health and Welfare will initiate payment of Federal funds, through the Department of Administration, to applicants for approved construction projects only.

4. Federal funds shall be paid to the Department of Revenue, State of Alaska (Title 18, Chapter 15, Sec. 200, AS 1962).

Personnel Standards Merit System

1. A statewide Civil Service system covers the State Agency personnel administering this State Plan.

2. The Personnel Division, Alaska State Department of Administration, administers the merit system.

3. This agency will furnish such data and information as is necessary to comply with the Act and Regulations.

Conflict of Interest

No full time officer or employee of the Department of Health and Welfare, or any firm, organization, corporation, or partnership which such officer or employee owns, controls, or directs, shall receive funds from the applicant, directly or indirectly, as payment for services provided in connection with the planning, design, construction or equipping of any project under this plan.

Financial Records

A. The Department of Health and Welfare will:

1. Comply with the provisions of the PHS Regulations by maintaining the necessary accounting records and controls.

2. Retain on file, for at least a period of five years beyond the participation in the program, all documents, accounting records, and controls related to any expenditure.

3. Make provisions for access to all records and project documents by the Administration, Social and Rehabilitation Service, or her duly authorized representatives.

B. The Department of Health and Welfare will take such steps as are necessary to assure that recipients of Federal funds:

1. Maintain adequate financial records and controls.

2. Retain, for a period of at least five years after final payment of Federal funds, all financial records and documents related to expenditures for their projects.

3. Make provisions for access to all records and project documents by the Comptroller General of the United States or his duly authorized representatives.

Fair Hearings

1. The Department of Health and Welfare will provide an opportunity for a fair hearing before the Department of Health and Welfare to every applicant who has requested federal aid in hospital and medical facilities construction, and who is dissatisfied with the action of the Department of Health and Welfare and appeals for a hearing.

2. Actions of the Department of Health and Welfare which entitle applicants to a hearing include the following:

(a) Denial of opportunity to make formal applications;
(b) Rejection or disapproval of applications; and
(c) Refusal to reconsider an application.

3. Appeals from decisions or action of the Department of Health and Welfare must be made by the applicant, in writing, within 30 days after the date of the adverse decision by the department.

4. The appellant will be notified in writing of the time and place of hearing. The time and place of hearing which is determined by the department, will be reasonably convenient for the appellant.

5. The appellant is entitled to be represented by friends or counsel, if he so desires. The appellant and other persons interested and concerned with the department's decision are entitled to present pertinent evidence in the way desired, subject to reasonable procedures of admissibility and methods of presentation.

6. The appellant is entitled to examine all evidence and to question opposing witnesses.

7. The presiding officer will be an official from the Secretary of State's office who did not participate in the action from which the appeal was made.

8. The decision of the Department of Health and Welfare will be made and, upon request of the appellant, will be transcribed and note available for examination.

Minimum Standards of Maintenance and Operation

A. The State Department of Health and Welfare adopts by reference the standards of maintenance and operation of facilities for the mentally retarded as adopted and published by the following organizations:

1. "Standards for State Residential Institutions for the Mentally Retarded", American Association of Mental Deficiency, published in volume 68, No. 4, January 1963.

2. "Child Welfare League of American Standards for Day Care Centers", Child Welfare League, 1960.

3. "Recommended Hospital Standards", National Institute of Hospital Standards.

B. Details of the Minimum Standards are given below. Because of the varied nature of Mental Retardation facilities, rarely will all the standards apply. These Standards are designed to serve as guides for a comprehensive statewide program. Each participating organization may contribute toward that objective to the maximum of its capabilities.

1. Introduction

The Minimum Standards of Maintenance and Operation for Mental Retardation Facilities are provided for and enforced by Public Law 88-164, Title I. The specific standards which follow are a compilation of the state's concept of what these standards should be.

The objective of this statewide program is to provide comprehensive services for the mentally retarded as close to their homes as possible.

Facilities that will help to implement a program emphasizing comprehensive treatment and continuity of care include: Mental retardation and psychiatric diagnosis, evaluation, and treatment; education; training; personal care; sheltered workshops; day care; and residential care. Other important services should be available, but in most cases will be in nearby facilities. Examples are medical inpatient and outpatient services, emergency room services, family service agencies, special education facilities in public and private schools, special facilities associated with the courts, rehabilitation centers, nursing homes, homes for the aged, and geriatric or chronic disease hospitals that provide services for the mentally retarded.

2. Governing Body

Each Mentally Retarded Facility shall be administered by a governing board. This board shall be responsible for the effective administration of the facility and shall establish policies for operation which conform to the requirements of this Plan and existing Mental Retardation legislation, such as:

a. Provide itself with by-laws, rules and regulations and other similar administrative guides.

b. Maintain written agreements with medical schools, hospitals, health and welfare agencies, and other agencies and individuals for exchange of services, scientific advancement, and professional, technical and administrative support.

c. Furnish evidence that a written policy regarding Title VI of the Civil Rights Act has been effectively presented to all employees, contractual and otherwise, of all departments, coupled with an indoctrination of admitting personnel concerning explanation of the policy, establishment of rules, and procedures for implementation.

d. Employ a competent executive for fiscal and operational functions, including sufficient details so as to reflect individual case costs, and to permit comprehensive reporting of biometric data.

e. Provide adequate insurance coverage, establish a regular schedule of board meetings, at least on a quarterly basis, insist that patient service records be maintained, and provide leadership for cooperative action and liaison with local health-interested agencies.

3. Medical Care and Services.

Services should include:

a. Diagnostic and evaluation - these services involve the diagnosis and evaluation of the individual; the appraisal of resources of the individual, his family, and the community; and the development of recommendations for a plan to help the individual realize his fullest potential.

b. Treatment - these services include medical and appropriate related ancillary services and therapies to provide for the improvement of the individual; physically, psychologically, and socially.

c. Education - these services include curricula of instruction geared to the needs of the retarded at various levels of retardation and in different age groupings.

d. Training - included in these services are training in motor skills, self-help, and activities of daily living; vocational training; and socialization experiences conducive to personality development.

e. Personal care - personal care services cover food, shelter, clothing, and medical care. Also included are special medical and nursing services directed at the prevention of regression in the retarded individual and stimulation of his maturation.

f. Sheltered workshop - these services include vocational evaluation, training, and paid work experience.

Facilities should include:

a. Diagnostic and evaluation - a facility providing diagnostic (and evaluation) services.

b. Day - a facility providing treatment, education, training, custodial care or sheltered workshop services on less than a 24 hour a day basis.

c. Residential - a facility providing treatment, education training, custodial care or sheltered workshop services on a 24-hour a day basis.

Each facility should have a qualified physician available, preferably on at least a half-time basis and responsible for the medical needs of the patients.

Each facility shall have a contract or agreement with a general hospital or other inpatient facility (if there are no other provisions for beds in the facility) in general proximity to the mental retardation facility, assuring the adequacy and completeness of medical emergency service when required.

The staff should adopt a policy encouraging general practitioners and other physicians to assist in the total care of the mentally retarded.

4. Medical Records

The quality of medical records are enhanced through the services of a registered medical record librarian on a full, part-time, shared, or consulting basis.

These records--often contained in permanent form in a locked file--should be available to authorized personnel and should be the repository of all pertinent patient information.

There shall be assurances that these medical records and clinical data will be developed and shared with the State Agency and made available to any institution to which a patient is transferred or referred by his physician, and that records shall be maintained on a current basis, and available for 20 years.

As a minimum, medical records should contain:

a. Summary of the problem with accompanying data.
b. Additional and confirming data.
c. Mental retardate determination, history and mental status.
d. Diagnosis.
e. Classification by standard nomenclature.
f. Treatment records, recommendations and plans.
g. Prognosis and influencing factors.

5. Auxiliary Services

Provision for an adequate supply of safe and sanitary linens and for housekeeping personnel trained and supervised to provide a safe and sanitary environment are basic responsibilities of each facility which provides residential services.

Where food is provided, the services of a trained dietician (American Dietetic Association member or eligible) on a full, part-time, shared, or consulting basis should be acquired.

Food Service personnel shall pay special attention to cleanliness, proper and adequate refrigeration, dishwashing and garbage disposal, preparation and transportation of food, and controls in use to insure proper diet therapy.

A food service manual, written menu plan, and a variety of special diets should be made available.

Food handlers shall have annual physical examinations, including serological tests.

6. Personnel - Staffing

Each Mental Retardation facility should provide for services of qualified:

Psychiatrist
Psychologist
Social Worker
Registered Nurses
Social Work Aides
Physicians
Occupational Therapist
Speech Therapist
Recreational Counselor
Licensed Vocational Nurses
Other personnel as will be required.

A planned program of staff training and conferences shall be provided. Liaison with other community health agencies shall be maintained for effective cooperation and interagency communications.

7. Safety

Mental Retardation facilities shall maintain a safe environment for patients, visitors, and staff and shall adhere to all local and State fire safety standards, codes, and requirements.

8. Physical Facilities

The Mental Retardation facilities shall comply with the general standards of construction and equipment as contained in Title I of Public Law 88-164, as well as applicable sections of these standards, codes, guides, and recommendations established by the State Agency, Alaska State Department of Health and Welfare:

Uniform Building Code
National Electric Code
National Plumbing Code
Life Safety Code
National Fire Code
Hospital Construction Standards
ASTM Specifications for Making Buildings Accessible to, and Usable by the Physically Handicapped.

C. Enforcement of the above standards will be accomplished in the following manner:

1. Projects approved under the Act after June 30, 1967. No proposals for funds under P.L. 88-164, Title I, Part C, have been developed in Alaska. The anticipated projects are covered in 2 (below)

2. Projects approved under the Act after July 1, 1969. Assurances are required that each facility shall provide the State Agency personnel access to its facilities, records, and operating

procedures for annual inspections, surveys, and an audited annual report on forms prescribed by the State Agency, and/or other appropriate agency of the State for submission of specific data.

At the present time the only licensed Mentally Retarded facility in Alaska is located at Valdez. This facility is a hospital and has been licensed in the same way as have other hospitals in Alaska. Mentally Retarded facilities per se. Also, there are no facilities other than Valdez, that meet the definition of a Mentally Retarded facility. Nonetheless, the present system of revocation of licenses will be invoked whenever a Mentally Retarded facility is not meeting minimum standards and when licensing regulations are completed. Deficiencies will be recorded during the inspections and surveys mentioned above, and a requirement as to the limit for correction will be described. These time limits will vary according to the particularity of immediate correction.

Transfer of Allotments

A. Transfer of allotment to another State.

If an arrangement is made with another State for the purpose of meeting a portion of the federal share of the cost of a project for the Construction of a facility for the Mentally Retarded. The Department of Health and Welfare will request transfer of its allotment to such State.

The Department is aware that in determining whether the facility with respect to which the request is made will meet the needs of Alaska, and that use of the specified portion of Alaska's allotment as requested by it, will assist in carrying out the purpose of the Part C of Title I of the Act, the Administrator, SRS, shall consider the accessibility of the facility, and the extent to which services will be made available to the residents of Alaska.

B. Transfer of allotment to the allotment for community mental health facilities.

The Department of Health and Welfare is aware of the above provisions and may utilize them by submitting a request in writing to the Administrator, SRS, that a specified portion of its allotment be added to the allotment of Alaska under Title II of the Act for the Construction of Community Mental Health Centers. It is understood that the Administrator, SRS, shall adjust the allotments of Alaska upon either:

1. Certification by the Department of Health and Welfare that it has afforded a reasonable period of time, not less than six months, during which application could be made for the portion so specified and that no approvable applications for such funds were received during that period of time; or

2. A demonstration satisfactory to the Administrator, SRS, that the need for community mental health centers is substantially greater than for facilities for the mentally retarded, such demonstration to include the concurrence of the Mentally Retarded Health Advisory Council.

Rate of Federal Participation

The State of Alaska uses the uniform rate. This has been set at 61%. The low rate is the result of low population and a high per-capita income.

Assurances of Non-Discrimination

The Department of Health and Welfare will obtain assurance from each applicant that all portions and services of the entire facility for the construction of which or in connection with which, aid under the Act is sought will be made available, without discrimination on account of race, creed, color, or national origin; and that no professionally qualified persons will be discriminated against on account of race, creed, color or national origin with respect to the privilege of professional practice in the facility.

Criteria for Allocation of Funds

Criteria which will govern the allocation of funds available under P.L. 88-164 are as follows:

1. The applicant must show by narrative program that the proposed facility will comprehend the full gamut of services required under section 416.12 Part 416 PHS Regulations for Grants for Construction of Facilities for the Mentally Retarded.

(a) This shall be interpreted to mean that, provided the master plan has been developed, the construction of the facility may be accomplished in phases. The first phase of construction, in all cases shall be the facility to accommodate diagnostic and treatment services, unless of course, a local, existing suitable service is available; the second phase of construction shall be that necessary to accomodate the service or services of greatest need as determined by diagnosis and evaluation. And so, the construction phases shall proceed until the master plan is realized.

2. The applicant shall demonstrate that any facilities planned under this program are not in any way a duplication of already existing, suitable facilities. At the same time, the applicant must show that arrangements have been accorded with the existing, suitable facilities before action can be taken on an application.

3. The applicant must show an intent to begin construction within a reasonable length of time.

4. The applicant must demonstrate financial ability to meet the costs of construction, maintenance and sustained operation of the proposed facility.

5. The applicant must show that adequate and proper professional personnel, in the respective services, will be available to staff the proposed facility.

6. A second application for the same type of facility in the same area would not be approvable for purposes of this State Plan.

7. A formal application must be completed by each sponsor on the prescribed PHS forms.

8. The fact that a project is excluded from the Project Construction Schedule for any of several reasons, will not change the priority rating. Such projects will be considered in each succeeding Project Construction Schedule.

Criteria for the Classification of Facilities under this Plan

Nonconforming facilities are classified as unsuitable because of one or more of the following factors:

1. Non-fire resistant buildings

2. Any building which is not structurally safe.

3. Any building which has not been designed for use as a mental retardation facility, and cannot be easily converted to such.

Good Cause for Other use of Facility

If within twenty years after completion of any construction for which a construction grant has been made the facility shall cease to be a public or nonprofit facility for the mentally retarded the Surgeon General in determining whether there is good cause for releasing the applicant or owner of the facility from the obligation to continue such facility as a public or other nonprofit facility for the mentally retarded, shall take into consideration the extent to which:

(a) The facility will be devoted by the applicant or other owner to use for another public purpose which will promote the purposes of the Act; or

(b) There are reasonable assurances that for the remainder of the twenty year period other facilities not previously utilized for the care of the mentally retarded will be so utilized and are substantially equivalent in nature and extent for such purposes.

Section 416.23 Notice of Change of Status of Facility

The State Agency shall promptly notify the Surgeon General in writing if at any time within 20 years after the completion of construction, any facility which received funds under Part C of Title I of the Act is transferred to any person, agency or organization not qualified to file an application under Part C, Title I of the Act or not approved as a transferee by the State Agency; or ceases to be a public or nonprofit facility for the mentally retarded as defined in the Act.

PROGRAM GOALS

4. Relating to meeting most important needs, including special attention to the poor.

1. Establish a Valid, Reliable, Data Base.

This goal is of primary importance, as it is prerequisite to the effective achievement of need satisfaction. The Department of Health and Welfare is keenly aware of the inadequacy of much of Alaska's Health data. Techniques are not yet available for estimating potential caseloads and evaluating demographic, cultural and economic changes. Nonetheless, the short term objective of compiling statistics available from all sources to measure need as accurately as possible, coupled with the long term objective of measuring precise and other indicators of need to be programmed into data systems, illustrate a positive direction toward the goal.

The types of services and facilities required will be influenced by the numbers of individuals in the various levels of retardation -- mild, moderate, severe, and profound -- and in the age classifications such as children (pre-school and school age) and adults. The availability of existing services and facilities for these levels as well as the total numbers of the retarded served, must be known in order to determine the services and facilities required to adequately meet needs. As factors are identified and need is determined, construction programs will be developed to plans such as this one.

2. Develop Programs for Poverty Areas.

This goal is directed at providing service to specific areas where need appears greatest. The goal also satisfies the instruction from the Federal Government that special attention be given the provision of services to the poor. The objectives cover the short range approach of setting up diagnostic and evaluative services in a low income area to the long range objective of careful establishment of need and development of comprehensive programs for construction and services.

Planning of services and facilities for the mentally retarded is affected by a wide range of factors and conditions. Planning will be conditioned by the number of retarded, the greater the prospective need for services and facilities. Hence, in areas of low income, cultural deprivation, and high density of population -- considerable need for services and facilities may be anticipated.

3. Meet Most Important Needs of the Retarded.

This goal is espoused as the ideal result of successfully limited programs. In Alaska, very little is being done to meet the comprehensive needs of the retarded. Emphasis has been and will be, to meet the most important needs as measured. Short range objectives include such items as development of a training facility in Valdez

so that new wards can be released for use. Consequently, patients cared for in another State can be returned to Alaska. (Two wards are now being used as a training facility). Long range objectives involve the construction of facilities and establishment of services in direct proportion to finances available and intensity of need. This is determined upon the first goal of gold reliable data resulting in accurate assessment of need.

This assessment starts with an evaluation of the existing services and facilities available for the retarded, both specialized and general, in terms of their capacity and potentials. It includes the formulation of a specific plan containing recommendations for the development of needed additional services and facilities and the translation of these recommendations into action. Not all new services or expansions of existing services will require added facilities. Frequently, additional programs can be housed within facilities currently in operation. Efficient planning entails careful analysis of the potentials of existing facilities to provide adequate functional space for new programs to be developed.

Two other important considerations have come to the forefront as the mental retardation horizon has widened. These are the extent to which a given facility actually serves the needs of the area it is intended to serve, and its flexibility to meet a variety of changes. The availability of services and facilities does not necessarily imply adequate utilization; significant problems arise in bringing services and clientele together.

However it must not be assumed that the State of Alaska is confronted with problems which Health and Welfare officials feel are insurmountable. The objectives are positive and afford solutions. An important long range objective is the development of community understanding and involvement in planning for, and assisting in, service and facility establishment for the Mentally Retarded. Enlisting the advice and counsel of the Comprehensive Health Advisory Council is an integral portion of this objective.

6. Provide Opportunities for Retarded to Attain Full Potential.

In the planning of services and facilities, cognizance of this goal calls for the establishment of specific objectives for each individual in each program, periodic reassessment of program objectives in terms of individual potentials, and a built-in flexibility within programs to permit quick and easy adaptation to changing requirements.

Despite any condition of limited funding, the objective of individual potential development is considered of utmost importance and is the core of effective rehabilitation. The Department of Health and Welfare has evolved the conviction that Mentally Retarded individuals receive every opportunity to expand, restricted only by a dearth of personnel and lack of funds to provide an optimal program. The short range objective is to develop potential on a group basis. This involves such things as training and sheltered workshops. These items can also be prime in individual development with individual attention.

5. Include Preventive Care As Part of Program.

A comprehensive attack on mental retardation should include prevention service as well as care and treatment services. Prevention is the most effective means of reducing the prevalence of mental retardation. A significant proportion of this handicapping condition results from conditions which are preventable with good medical care. It is estimated that full application and utilization of existing knowledge through action on a broad front to correct adverse community conditions, combined with specific preventive measures, would eliminate at least half of the new cases of mental retardation. Short range objectives involve such things as the implementation of training and sheltered workshop projects within established and developing Mentally Retarded programs.

Long range objectives include the initiation of a parent education program which will aid in much earlier identification of mentally deficient children, plus developing a system whereby potentially mentally deficient children will gain sufficient intelligence to function quite well in society, and perhaps never be tagged as Mentally Retarded. The objective of evoking the participation of the community in planning and implementing methods of achieving prevention, rates high in Health and Welfare priorities. A major effort furthering this latter objective is the maximum, effective, utilization of the Comprehensive Health Advisory Council.

B. Relating to Utilization of Generic Services

1. Establish Community Agency Membership in, and/or Support for the Comprehensive Health Advisory Council.

This goal is the key to maximum, effective utilization of generic services. Before it is possible to realize a totally coordinated delivery of care to the Mentally Retarded, (and others) a commitment to Comprehensive Health Planning must exist. It is impossible to provide membership to the Health Advisory Council for representatives of all generic services. Nonetheless, the agencies not represented can, and should, not only support the CHAC, but contribute, by means of one of the Council representatives, to the planning. As community agencies become partners in health, to borrow the phrase first espoused in "Health is a Community Affair", thereby working together and avoiding duplication and overlapping of services, a true Comprehensive Health Planning picture is nurtured. The next logical step is to evolve a means whereby coordination of health services is possible. This means the formation of a State Health Advisory Council, if none exists, participation in Council planning, and support for decisions made by the majority.

Stimulation of interest in the planning of services and facilities for the mentally retarded must come from the understanding, support,

and leadership of professional groups involved in the field of mental retardation and allenhance, leaders in commerce, industry, and labour, as well as the other facets of community life, including representatives of the poor. In Alaska, this is the Comprehensive Health Advisory Council.

The short range objectives adopted by the Department of Health and Welfare has been to contact officials of various community agencies when certain openings are available on the Council. If willing, the officials then pick from their number, a person to represent them. The person must also be nominated by the Governor and confirmed by the legislature.

The long range objective is to tell the story of Comprehensive Planning to as many communities and agencies as possible. In addition, the formation of local voluntary planning agencies -- all part of the total planning picture -- aid in developing a working concept of planning and a stimulation to agency involvement in planning.

2. Encourage Service for the Retarded Within Generic Service Agencies.

The degree to which existing community services are available to the retarded will have an impact on the planning of services and facilities. Most planning areas have some type of generic services and facilities open to the mentally retarded. Efficient and realistic planning necessitate identifying these services and facilities and analyzing programs which they provide, in terms of the total needs of the retarded individuals in the area.

Planning should involve utilization of community services insofar as feasible and practical. The value accruing to the individual and his family make it desirable to encourage the inclusion of the retarded within the framework of community programs. The effectiveness of these programs will depend upon the degree of understanding of the special needs of the retarded and the consideration given to these special needs by personnel administering the programs.

To the extent appropriate and practicable, services and facilities should be planned for availability within the community. This permits utilization of family and community resources, helps sustain family interest in the individual, and facilitates assimilation of the retarded into normal patterns of community life. Efficient planning for the retarded within the community planning activities in the areas of health, education and welfare to ensure full utilization of available resources and to avoid duplication wherever possible.

A short range objective currently employed by the Department of Health and Welfare is staff contact, often through the Comprehensive Health Advisory Council with various generic service officials for the purpose of influencing provision of care to the mentally retarded. Long range objectives include the formation and support of inter-agency councils. These councils can become integral entities within the planning process. They can insure a maximum utilization of the services of member agencies and can coordinate their planning efforts with those of the Comprehensive Health Advisory Council. Another objective is the development and implementation of a concentrated education program, whereby the importance of providing generic services is expounded.

C. Relating to Coordination of Programs Throughout the State

1. State Development of Comprehensive Health Planning

This goal is of such importance that it should be stated despite claim or fact that it already is an accomplished feat. Also, when any state has developed Comprehensive Planning, an ongoing effort is imperative. Coordination of programs throughout the State is impossible without development of an effective system of Comprehensive Health Planning. Naturally, some coordination, mainly localized, will and has resulted with no state body. This type of coordination is limited and should be fit into the total pattern before the optimal delivery of service is realized. The State of Alaska has taken the first steps in the direction of the above goal. Objectives such as the formation of an Office of Comprehensive Planning, receipt of a Sec. 314 (a) grant, and the formation of a Comprehensive Health Advisory Council are some recorded achievements. Further objectives aimed toward the goal of State Development of Comprehensive Health Planning include the short range objective of staff contact with agencies to stimulate cooperative efforts, to the long range objective of formation of area-wide planning agencies to complete the total planning picture. The involvement of other state agencies is another objective which is vital to the stated goal. Alaska has included such agencies in the State Health Plan, and will continue the effort in this direction.

2. State Plans with Coordinated Activities Espoused.

This goal has been given some attention as it related to goals already discussed. Any State Plan, be it of a special nature such as this one, or of a more broad nature such as the Comprehensive Health Plan, must provide for coordination of activities before the value of the Plan has reached its full potential. Each entity of the health care system must mesh into the workings of the service and facility network. It is the aim of the Department of Health and Welfare that all programs within the State serve the interest of the retarded (if applicable) as well as the several other groups within this highly heterogeneous State. The short range objectives include the assurance that all State Plans drafted by staff personnel contain careful development of the philosophy of coordination. Long range objectives include the augmentation of an in-service training program which gives staff a total awareness of the importance of coordination and methods of implementation. The development and support of Local Health Planning Agencies [Sec. 314 (b)], Health Councils, Interagency Councils, and others, all dedicated to coordination of Health Services, is a prime long range objective.

3. Elimination of Duplication and Fragmentation of Services

This goal is the desire of all Public Health professionals who are committed to effective delivery of services as opposed to independent

approaches stemming from vested interests. It is a goal which meets some degree of accomplishment when previous goals mentioned have been gained. It is a major, inseparable, part of the total picture of Comprehensive Health Services and Facilities. Objectives established for other goals also assist this goal. Examples are: Staff contact with agencies involved in delivery of services, Formation and Support of Comprehensive Health Advisory Council and other Health Councils commited to coordination, Community Involvement, and State Plans Drafted with Coordination as a main theme. A short range, "fire-fighting" objective is to identify all services and facilities which are in effect competing with each other, and convince the officials involved, to curtail in some areas, add in others.

Long range objectives encompass the highly important and difficult task of developing an awareness on the part of all concerned, as to the methods and worth of integrating services. Only in this way can a total commitment develop, allowing the mentally retarded (and others) to avail themselves of unduplicated, non-fragmented, totally coordinated, system of delivery of care.

POLICIES

A. Coordination with Other State Activities that Service the Mentally Retarded.

It is the intent of the Department of Health and Welfare that goals and objectives, as discussed above, be incorporated into planning and action programs of other Alaska efforts such as Vocational Rehabilitation; Comprehensive Health Planning and Areawide Planning under P.L. 89-749; and Planning and Construction of Hospitals, Community Mental Health Centers and other related health facilities, to the extent feasible and appropriate. Joint goals and objectives for the care and treatment of the retarded will be implemented when possible. Corresponding planning areas will be encouraged. Further details are given under "Program Goals, C., 3, 3, and 5". All State agencies are considered (when applicable) important components of the total care and rehabilitation of the Mentally Retarded.

B. Maximum Effort to Assist the Retarded Living in Disadvantaged or Poverty Areas.

It is the intent of the Department of Health and Welfare that the needs of the retarded shall be made a part of all planning and action programs designed to give special attention to the disadvantaged residing in both urban and rural areas. This includes coordination with such programs as Model Cities and other HUD projects affecting the retarded; Project Head Start and other OEO projects affecting the retarded; the various Welfare and Social Service agencies; the Alaska Area Native Health Service; the Bureau of Indian Affairs, the Indian Health Service; the State Department of Labor, and other agencies with special Retarded training programs; plus many other agencies who are involved in the total delivery of care to which the Retarded should have access. Further details are given under "Program Goals, A.,2.," and are implied throughout the entire list of goals and objectives.

C. Maximum Utilization of Generic Services

It is the intent of the Department of Health and Welfare that the Mentally Retarded within the State of Alaska, (and the few residents receiving care elsewhere) be able to utilize to a maximum degree, the services found in the fields of Rehabilitation, Health, Education, Employment, and Welfare. The policy has been established whereby the Mentally Retarded may be maintained in the mainstream of community life to the extent feasible, using maximum involvement of community resources. Details are given above under "Program Goals, B., 1, and 2" and elsewhere throughout the list of goals and objectives.

It is the intent that the Mentally Retarded individual have services available to him regardless of his ability to pay for such services. Many retarded have associated handicapping conditions. Services are provided for these conditions in the Valdez facility, and are part of this plan for future development. Please see "Program Goals, A, 2, 3, 4, and 5", as well as later in this plan where future services and facilities are discussed.

D. Effective Development and Implementation of Planning and Construction Programs.

It is the intent of the Department of Health and Welfare to do all possible to assure coordination of services and elimination of duplication of services. Details regarding this are given above under "Program Goals, B., 1 and 2; C., 1,2, and 3," as well as throughout the discussion on Program Goals. Please refer to "Methods of Administration" for details regarding the administration of the Mentally Retarded Program in Alaska, including such things as the effective development and implementation of Mentally Retarded Construction Programs in Alaska. The Development of the Construction Program is detailed immediately following this section of the Plan. It is hoped that each patient will be able to receive services and have access to facilities, which satisfy his total need. A listing of the basic services and facilities are repeated here. Please see "Methods of Administration, Minimum Standards of Maintenance and Operation, B. 3 for details.

Services:

1. Diagnostic and Evaluation
2. Treatment
3. Education
4. Training
5. Personal Care
6. Sheltered Workshop

Facilities

1. Day
2. Residential
3. Diagnostic and Evaluation

DEVELOPMENT OF A CONSTRUCTION PROGRAM

The following program for the construction of Mental Retardation facilities in Alaska conforms with the requirements of Sections 133 and 134 of PL88-164, and Title 45, Code of Federal Regulations, Chapter IV, Part 416.

A. Delineation of Planning or Service Areas.

Although it is recognized that various types of facilities and service centers must correspond to service areas which are compatible with accessibility and practicality, overall planning areas have been established to determine general priorities. Within these areas, called catchment areas, projects will be developed which satisfy needs according to their particular service area. Comprehensive Health Planning as implemented through policies, goals, and objectives discussed earlier, is intended to ensure coordination of the many providers of service so that service areas do not conflict. The primary purpose of the catchment area is to allow accurate statistical recording which can then be used to measure need in a general area. Each catchment area has been selected to represent a geographical compilation of communities which are positioned such that interrelationships and interdependencies are or could be in effect. This is meant to establish a logical base for Mentally Retarded (and other) services.

This ideal has the constraint of current systems of data collection. The greatest source of workable data is based on Alaska's Election Districts. A map of these districts is included on the next page. The districts do not entirely meet the criteria mentioned above. Nonetheless, it is impossible to have sufficient measurement of need if the Election District configurations are not used. A few area-wide planning bodies will likely overlap boundaries. This will not negate the value of the catchment areas. The map also shows the location of indian reservations in Alaska.

For purposes of Mental Health and Mental Retardation planning, the state has been divided as follows:

Area 1. Ketchikan Catchment Area -
Election Districts 1 and 2

Area 2. Juneau Catchment Area -
Election Districts 3, 4 and 5

Area 3. Anchorage Catchment Area -
Election Districts 6, 7, 8, 9, 10 and 13

Area 4. Kodiak Catchment Area -
Election Districts 11 and 12

Area 5. Bethel Catchment Area -
Election Districts 14 and 19

Area 6. Fairbanks Catchment Area -
Election Districts 15 and 16

Area 7. Nome Catchment Area -
Election Districts 17 and 18

ALASKA ELECTION DISTRICT MAP

CATCHMENT AREAS AND INDIAN RESERVATIONS

Catchment Area 1-Ketchikan - Election Districts 1 & 2
Annette Islands Reservation - R1

Catchment Area 2-Juneau - Election Districts 3, 4 & 5
Tenakee-Inlet Reserve - R2
Klukwan Reservation - R4
Chilkat Reserve - R3

Catchment Area 3-Anchorage - Election Districts 6, 7, 8, 9, 10 & 13
Tyonek Reserve - R5
Copper Center Reserve - R7
Eklutna Reserve - R6
Tatitlek Reserve - R8

Catchment Area 4-Kodiak - Election Districts 11 & 12
Karluk Reserve - R9
Nunam Reserve - R11
Akhiok Reserve - R10

Catchment Area 5-Bethel - Election Districts 14 & 19
Akiak Reserve - R12
Mountain Village Reserve - R13

Catchment Area 6-Fairbanks - Election Districts 15 & 16
Nenana Timber Reserve - R14
Venetie Chandalar Reservation - R16
Tetlin Reserve - R15
Ft. Yukon Reserve - R17

Catchment Area 7-Nome - Election Districts 17 & 18
Wainwright Reserve - R18
Stanton Bay Reserve - R20
Unalakleet Reserve - R22
Wales Reservation - R24
St. Lawrence Island Reindeer Reserve - R26
Diomede Reservation - R27
White Mountain Reserve - R19
Reindeer Reserve - R21
Cape Denbigh Reserve - R23
Kobuk River Reserve - R25

CATONSVT AREA MAP

DESIGNATING ELECTION DISTRICTS,
AND SHOWING LOCATIONS OF INDIAN
RESERVATIONS.

A map of each catchment area is included with the narrative regarding the particular area.

B. General Characteristics of Planning or Service Areas.

Placing a silhouette of Alaska on top of an outline of the "lower 48", (same scale) helps to illustrate the immensity of the state. Please see below. It stretches coast to coast. It covers the Midwest from the northern border to Oklahoma City. Alaska's total land area is approximately one-fifth that of the rest of the United States. Alaska's coastline is extremely large - 34,000 miles.

ALASKA

586,400 Square Miles
34,000 Miles of Coast-Line

Many conditions exist in Alaska which make its problems unique. Size alone makes the administration of any program unwieldy, and adding the factors of undeveloped transportation and communication systems compounds the problems.

Since the purchase of Alaska more than a hundred years ago by the United States, the natural resources have been exploited. Until statehood, investments and improvements made in Alaska by individuals and the Government were not made to improve conditions for the Territory, but to further the benefits of exploitation. During World War II, when the territory of Alaska became an important military outpost, the United States Government developed a few main roads and communication systems. However, at the present time, not more than a half dozen towns of one thousand population are connected by roads. In the few years since statehood, many bush airfields have been established to serve some of the more populated areas, but there are hundreds of small settlements where transportation of people is limited to dog sled or river boat, or in case of extreme emergency, by light plane or helicopter.

Approximately sixty percent of the population of the state live in, or immediately adjacent to, the four major cities. The remaining forty percent have no reasonable ground transportation to these cities. Anchorage and Fairbanks are connected by rail and road, but travel time between the [illegible] by the Marine Transportation system which requires twenty-four hours, at a minimum, to travel from one city to the other. All four cities are connected by airlines with service daily, except when weather conditions prohibit flights.

Not more than four towns with a population of one thousand inhabitants or more are connected to the four major cities by highway. Air travel is the only means of transportation to other towns and villages, and although many are on regularly scheduled routes, travel is somewhat uncertain during the winter months, and is very expensive.

The topography of Alaska is extremely mountainous, which would make it impractical to expand the ground transportation system, since the cost of construction could not be justified in terms of the people served. The maintainence and operation of roads during the winter months would be impossible.

Many Alaskans, mostly native but some white, have a subsistence economy similar to that which existed in other states more than a hundred years ago. Some settlements are temporary and move from place to place as conditions for hunting, fishing and trapping change. People living in these conditions have little opportunity to receive the benefits of health programs and educational opportunity. In remote areas of Alaska children are born, many prematurely, without benefit of pre-natal care or post-natal care. In many cases the parents speak the native language and, since these languages are not written, the children have no opportunity to learn to read or profit from books which they might read as they grow older.

Almost half of the people in Alaska live outside of communities which offer adequate health and educational services. The Public Health Service operates five hospitals which serve natives only, except in case of emergency. The major purpose for this service was to control tuberculosis, and most of the hospital beds are designated for this purpose. The Bureau of Indian Affairs has established many elementary schools and a boarding high school for native children, but none are established unless there are fifteen school-age children in a settlement. The Public Schools Department of the Territory and State has established many rural elementary schools, and generally will establish a school where there are twelve or more elementary school-age children. It is easily understood that it is difficult to obtain qualified teachers who will live under the primitive conditions which exist in these locations, resulting in less that adequate educational programs.

Alaska's resources continue to be attractive to industry. Oil discovery on the North Slope (of the Brooks Range) in Arctic Alaska has thrust Alaska into the nation's and world's spotlight. Nine hundred million dollars was received by the State of Alaska in the September 1969, oil lease sale. As people rush to Alaska, many to be disappointed regarding rapid riches, other industries are planning major investments. A one hundred million dollar Pulp Mill is planned for Berner's Bay north of Juneau, and a huge Iron Ore plant is planned for south of Juneau, a Brewery is planned for Anchorage, and Oil Refinery is planned for Fairbanks, and further oil development is planned on the Kenai Peninsula. Add to this planned, Sawed's success, a domed modern city accross from Anchorage. The oil pipeline to carry oil from the Arctic to Valdez. The rumored discovery of platinum near Bethel, plus mineral deposits of Asbestis near Fairbanks and the possibilities of renewed gold mining, and a huge industrial complex becomes apparent. With this surge, health problems are increasing tremendously. The effect on Mental Retardation is difficult to assess at this time. It very likely will increase, however.

The catchment areas mentioned earlier are discussed in more detail below:

1. Catchment Area One - Ketchikan (See map next page)

   Catchment Area One is located in the southern part of Alaska and comprises Election District I and 2. Geographically, the area is mountainous except along the coast and is comprised of numerous islands. The area is noted for its high annual rainfall and large rain forests. The climate is moderate with temperatures ranging from zero to 90 degrees. The principal industries are lumbering and fishing. The 1968 population estimate for this area is 19,700. Ketchikan is the largest city in the area with a population of nearly ten thousand. Other sizable towns are Petersburg, Wrangell, Metlakatla, Annette, Craig, Klawok and Hydaburg. All of the towns have elementary school facilities and all except three have secondary schools. Ketchikan is the only town which provides educational services for the mentally retarded. Even here, the program is relatively new and only a small percent of those needing special education are included in the program.

[illegible]

[illegible]

REGION 1
KETCHIKAN CATCHMENT AREA
Election Districts 1 and 2.

REGION 2
JUNEAU CATCHMENT AREA
Election Districts 3, 4 and 5.

- ELECTION DISTRICT BOUNDARIES ONLY.

- CATCHMENT AREA BOUNDARIES AND ELECTION DISTRICT BOUNDARIES FOR THE NUMBERED DISTRICT SHOWN.

Ketchikan, Petersburg and Wrangell have hospitals, but the other communities depend largely on itinerant public health nurse for routine health services.

Roads in this area are practically non-existent. Ketchikan, Petersburg and Wrangell are ports of call for the State Marine Highway System, but it is impossible to drive an RV from any other town in the area to the city of Ketchikan. Most of the area is serviced by a scheduled airline or by charter services. These operate most of the year, but during the winter months flights may be delayed or cancelled due to adverse weather conditions.

This area is served on an infrequent basis by a mental health team with offices in Juneau. Teachers, Public Health nurses, doctors, ministers or others may refer suspected mentally retarded individuals to the mental health team for testing and evaluation

The following statistical information is provided for the Ketchikan Catchment Area. Further information can be obtained from the priority tables.

a. Demographic Data

Population Figures by Age, Sex and Race-1960 Census

	All Ages	Under 19	19-44	45-64	65 and Over
All Classes	16,023	6,868	5,328	2,967	867
White Male	6,528	2,222	2,826	1,667	809
White Female	5,057	1,949	1,867	936	215
Nonwhite Male	2,288	1,222	619	307	140
Nonwhite Female	2,154	1,181	612	257	104

b. Socio-economic Data

Per capita income 1967 - $2,151
Unemployment rate 1968 - 8.7
Welfare payments U.S. Bureau of Indian Affairs 1967 - $61,153
Welfare payments Alaska Department of Health & Welfare - $309,428
Median school years completed 1960 census (male 25 years & over) - 10.9
Median school years completed 1967 census (female 25 years & over) - 11.1

c. Indian Reservations

The Annette Island Indian Reservation is located in the Ketchikan catchment area. Location is shown on Election District map.

d. Health Facilities

(1) Alaska Psychiatric Institute - 225 beds. This facility is located in Anchorage and serves the entire state.

Southeastern Regional Mental Health Clinic. This facility is located in Juneau and serves catchment areas 1 and 2.

(2) Mentally Retarded Facilities

Stanton Memorial Hospital - 150 beds. This facility is located in Valdez (often referred to as "Valdez") and serves the entire state.

(3) General Hospitals

Ketchikan General Hospital - 60 general beds / 40 extended care beds.
Wrangell General Hospital - 12 general beds.
Petersburg General Hospital - 15 general beds / 12 extended care beds.

(4) Public Health Service

Ketchikan Health Center
Annette-Metlakatla Health Center

(5) Other Facilities

Ketchikan Halfway House for Alcoholics

e. Medical Manpower (Practicing M.D.s)

aa. Private Practice

City	General Practice	Internal Medicine	General Surgery
Ketchikan	6	1	1
Petersburg	2		
Wrangell	1		

bb. U.S. Public Health Service

Facility	General Practice
Annette-Metlakatla Health Center	1
Ketchikan Health Center	2

f. Medical Manpower (P.H.N.s)

State of Alaska, Southeastern Regional Office, Juneau.

Communities	P.H.N.
Kake (share with Angoon in Catchment Area 2)	1
Ketchikan	2
Petersburg and Wrangell	1
Cape Pole, Coffman Cove, Craig, Dry Pass, Hydaburg, Klawak, North Whale Pass, Port Alice, Ratz Harbor, Red Bay, Thorne Bay, Tuxekan, Twelve Arm	1

g. Other Services

American Red Cross, The Salvation Army, Alaska Heart Association, Alaska State Elks Association, Cerebral Palsy Foundation Commission, Inc., Alaska Crippled Children's Association, American Cancer Society, Alcoholics Anonymous and National Foundation.

2. Catchment Area Two - Juneau (See map previous page)

Catchment area two is located in southeastern Alaska and is bordered on the south by catchment area one, on the north by catchment area three, on the east by Canada, and on the west by the Pacific Ocean. It is made up of election districts 3, 4 and 5. Geographically, the area is mountainous except along the coast and encompasses numerous islands. The area has a high annual rainfall and large rain forests. The climate is moderate with temperatures ranging from -20 degrees to 85 degrees. The principal industries are fishing and lumbering. Juneau, the principal city in the area, is the capital of the State and the seat of government. Many Federal offices are located in Juneau, including Headquarters Commandant, 17th Coast Guard District. Transportation within the area and to other ports of the State is by air or marine highway system. Juneau, Haines, Skagway and Sitka, in area #2, are connected by the Marine Highway System. Most of the year it is possible to drive from Haines to towns in Canada which are located on the Alcan Highway. Such other towns as Hoonah, Angoon and Pelican may be reached only by air service.

All of the towns mentioned in area #2 have elementary school facilities and most have small secondary schools. Juneau is the only school district in the area providing special classes for the mentally retarded. The limited number of classes there would indicate that only a small percent who might need this service are receiving it. A few mentally retarded children in Sitka receive special education.

The following statistical information is provided for the Juneau catchment area. Further information can be obtained from the priority tables.

a. Demographic Data

The 1968 population estimate for this area is 25,200.

Population Figures by Age, Sex and Race-1960 Census

	All Ages	Under 19	19-44	45-64	65 and Over
All Classes	19,580	8,008	6,754	3,538	1,038
White Male	7,452	2,556	2,661	1,696	539
White Female	6,321	2,409	2,347	1,296	269
Nonwhite Male	2,868	1,001	570	272	91
Nonwhite Female	1,799	1,510	862	268	99

b. Socio-economic Data

Per capita income 1967 - $2,919
Unemployment rate 1968 - 5.1
Welfare payments U.S. Bureau of Indian Affairs 1967 - $96,122
Welfare payments Alaska Department of Health & Welfare - $205,256
Median school years completed 1960 census (male 25 years & over) - 11.2
Median school years completed 1960 census (female 25 years & over) - 12.1

c. Indian Reservations

The Klukwan Indian Reservation, Chilkat Reserve, and Yendistucky Reserve are located in the Juneau catchment area. Locations are shown on election district map.

d. Health Facilities

Psychiatric

(1) Alaska Psychiatric Institute - 225 beds. This facility is located in Anchorage and serves the entire State.

Southeastern Regional Mental Health Clinic. This facility is located in Juneau and serves catchment areas one and two.

(2) Mentally Retarded

Harborview Memorial Hospital - 150 beds. This facility is located in Valdez (often referred to as "Valdez") and serves the entire State.

(3) General Hospitals

Greater Juneau Borough Hospital - 67 beds (now 76 bed, 8 ICF to be built)
Sitka General Hospital - 28 beds

(4) Public Health Service

Mt. Edgecumbe Hospital - 147 beds
Juneau Health Center - outpatient facility

(5) Other Facilities

Juneau Halfway House for Alcoholics

e. Medical Manpower (Practicing M.D.s)

	General Practice	General Surgery	Other Surgery	Pediatrics	Internal Medicine	Psychiatry
Private Practice						
Haines	1					
Juneau	5	1	1 (Thoracic)	1	1	
Sitka	3	1	1 (Orthopedic)			
State of Alaska						
Juneau					1	
U.S. Public Health Service						
Juneau	2					
Mt. Edgecumbe	6	1		1	1	

f. Medical Manpower (P.H.N.s)

State of Alaska, Southeastern Regional Office, Juneau

Communities	P.H.N.
Juneau	3 central staff, 1 regional supervisor, 2 Juneau Health Center
Elfin Cove, Excursion Inlet, Gustavus, Hoonah, Pelican, and Tenakee	1
Haines, Klukwan, Port Chilkoot, Skagway, and Yakutat	1
Angoon (share with Kake in Catchment Area 1)	1
Sitka, False Island, St. John the Baptist Bay	1

g. Other Services

American Red Cross, Salvation Army, Alaska Mental Health Association, Alaska Heart Association, Alaska Tuberculosis Association, American Cancer Society, Alcoholics Anonymous, and National Foundation.

3. Catchment Area Three - Anchorage (see map next page)

Catchment Area three is located in southcentral Alaska and is made up of election districts 6, 7, 8, 9, 10 and 13. Geographically, the area is flat with mountain ranges through the central part and along the coast. The climate varies in the winter from -35 degrees in Anchorage to -80 degrees at Tok on the Alaska-Canadian border. Summers range from 60 degrees along the coast to 95 degrees in the interior. The principal industries are petroleum, fishing, tourism, farming and mining. The city of Anchorage is by far the largest of the cities in this area as well as the State. The special 1968 census found a population of 45,096 in Anchorage. Transportation in and out of Anchorage is more developed than in any other city. Both domestic and international airlines are serviced through the modern international airport. Highways connect Anchorage with Palmer, Fairbanks, Seward, Valdez and towns on the Kenai Peninsula, such as Homer, Soldotna and Kenai. Scheduled airlines serve most of the towns and villages regularly, although some of the smaller villages may have service only once or twice each week.

Anchorage has several non-profit agencies such as the Crippled Children"s Association and the Association for the Mentally Retarded. The school system is doing a great deal in educating and training the physically and mentally handicapped.

There are two large military installations in this catchment area:

a. Elmendorf Air Force Base b. Fort Richardson

The following statistical information is provided for the Anchorage catchment area. Further information can be obtained from the priority tables.

a. Demographic Data

The 1968 population estimate for this area is 139,200.

Population Figures by Age, Sex and Race-1960 Census

	All Ages	Under 19	19-44	45-64	65 and Over
All Classes	105,701	42,493	48,800	12,723	1,685
White Male	52,921	19,377	25,763	6,851	930
White Female	41,413	17,884	18,138	4,809	582
Nonwhite Male	6,220	2,739	2,745	630	106
Nonwhite Female	5,147	2,493	2,154	433	67

REGION 3
MENTAL HEALTH AND MENTAL RETARDATION
ANCHORAGE CATCHMENT AREA
Election District 6, 7, 8, 9, 10, & 13

b. Socio-economic Data

Per capita income 1967 - $3,125
Unemployment rate 1968 - 8.7
Welfare payments U.S. Bureau of Indian Affairs 1967 - $343,101
Welfare payments Alaska Department of Health & Welfare 1967 - $574,992
Median school years completed 1960 census (male 25 years & older) - 11.2
Median school years completed 1960 census (female 25 years & older) - 11.2

c. Indian Reservations

The Copper Center, Tatitlek, Tyonek and Eklutna Indian Reserves are located in the Anchorage catchment area. Locations are shown on Election District map.

d. Health Facilities

(1) Psychiatric

Alaska Psychiatric Institute - 225 beds. This facility is located in Anchorage and serves the entire State.

Southcentral Regional Mental Health Clinic. This facility is located in Anchorage and serves catchment areas three, four and five.

(2) Mentally Retarded

Harborview Memorial Hospital - 150 beds (also 15 local area general beds). This facility is located in Valdez, which is in the Anchorage catchment area. The facility (often referred to as "Valdez") serves the entire State.

(3) General Hospitals

Providence Hospital, Anchorage	125 general beds/ 25 long term care beds
Anchorage Community Hospital, Anchorage	45 general beds
Harborview Memorial Hospital, Valdez	15 general beds/150 mentally retarded beds
Cordova Community Hospital, Cordova	22 general beds
Faith Hospital, Glennallen	6 general beds
Homer City Hospital, Homer	5 general beds
Seward General Hospital, Seward	32 general beds
Valley Hospital, Palmer	25 general beds

(4) Public Health Service

Anchorage Medical Center, Anchorage	307 beds
Kanakanak Hospital, Kanakanak	31 beds

(5) Military

U.S.A.F. Hospital, Elmendorf AFB 200 beds

e. Health Manpower (Practicing M.D.s)

aa. Anchorage Private Practice

Anesthesiology - 5
Dermatology - 1
E.N.T. - 4
General Practice - 24
Internal Medicine - 10
Neurology - 1
O.B. Gynecology - 4
Ophthalmology - 2
Pathology - 4
Pediatrics - 5
Psychiatry - 4
Radiology - 3
Surgery, General - 9
Surgery, Neuro- - 1
Surgery, Orthopedic - 5
Surgery, Plastic - 1
Surgery, Thoracic - 3
Urology - 1

bb. Other Cities Private Practice

City	General Practice	General Surgery
Cordova	1	
Dillingham	1	
Eagle River	1	
Glennallen	1	1
Homer	1	
Kenai	3	
Palmer	2	
Seward	1	1
Soldotna	2	
Tok	1	
Valdez	1	

cc. U.S. Army - Fort Richardson Dispensary

General Practice	Ophthamology	Pediatrics	Psychiatry
7	1	2	2

dd. Alaska Department of Health and Welfare

City	Epidemiology	General Practice	Psychiatry
Anchorage	1	3	3

ee. U.S. Public Health Service

Anchorage

Anesthesiology - 1
E.N.T. - 1
Epidemiology - 1
General Practice - 21
Internal Medicine - 3
Mental Health - 1
O.B. Gynecology - 1
Ophthalmology - 2
Orthopedic - 1
Pathology - 1
Pediatrics - 2
Radiology - 2
Surgery - 3

Kanakanak

Three in general practice

ff. U.S.A.F. Hospital (Elmendorf Air Base - also used by personnel of Ft. Richardson)

Aerospace Medicine - 1
Allergy - 1
Anesthesiology - 2
Cardiology - 1
Dermatology - 1
General Practice - 6
Histopathology - 1
Internal Medicine - 4
Neurology - 1
O.B. Gynecology - 5
Ophthalmology - 1
Otolaryngologist - 3
Pathology - 1
Pediatrics - 5
Psychiatry - 4
Radiology - 2
Surgery, General - 5
Surgery, Orthopedic - 3
Urology - 3

f. Medical Manpower (P.H.N.s)

aa. Greater Anchorage Area Borough Health Dept. - 16 P.H.N.s

bb. State of Alaska, Southcentral Region

Communities	P.H.N.s
Igugig, Iliamna, Kokhanok, Nondalton, Pedro Bay (shared with St. George and St. Paul of Kodiak Catchment Area)	1
Cape Yakataga, Cordova, Tatitilek, and Valdez	1
Ekwak, Koliganek, Manokotak, New Stuyahok, and Togiak (shared with Goodnews Bay and Platinum of Bethel Catchment Area)	1
Aleknagik, Clarks Point, Ekuk, Greater Dillingham, Portage Creek	1
Chistochina, Chitina, Cooper Center, Copper Valley School, Gakona, Glennallen, Portion of Glenn Highway and Richardson Highway within Anchorage Catchment Area, Gulkana, Kenney Lake, Mentasta, and Tazlina (shared with five communities from Fairbanks Catchment Area)	1
Anchor Point, Clam Gulch, Cohoe, English Bay, Homer, Kasilof, Ninilchik, Port Graham, and Seldovia	1
Kenai, North Kenai, Soldotna, Sterling, and Tyonek	1
Glenn Highway area of Matanuska Valley, Palmer, and Corrections Adult Conservation Camp	1
Big Lake, Houston, Kashwitna, Knik, Mahoney-ville, Montana Creek, Sunshine, Talkeetna, Wasilla, Willow, Corrections Youth Conservation Camp	1
Egegik, King Salmon, Levelock, Naknek, Pilot Point, Port Heiden, South Naknek, and Ugashik (shared with six communities from Kodiak Catchment Area)	1
Cooper Landing, Hope, Moose Pass, Seward, and Whittier	1

g. Other Services

American Red Cross, Young Men's Christian Association, The Salvation Army, Booth Memorial Home, Alaska Mental Health Association, Eye, Ear, Nose and Throat Association of Alaska Inc., Alaska Heart Association, Alaska State Elks Association, Cerebral Palsy Foundation Commission, Inc., Alaska Crippled Children's Association (mentioned above), Alaska Tuberculosis Association, Inc., American Cancer Society, Alcoholics Anonymous, National Foundation, and Association for Retarded Children of Anchorage (mentioned above).

4. Catchment Area Four - Kodiak (map on next page)

Catchment area four is located in southwestern Alaska and is made up of election districts 11 and 12. Geographically the area is made up of islands in the Gulf of Alaska and the Aleutian Chain. The climate is moderate with temperatures averaging from 30 degrees in winter to 55 degrees in summer. The principal industries are fishing, cattle and sheep raising, fur seal operations, nuclear testing operations and the military. The 1968 population estimate for this area is 18,700. Military personnel account for approximately 50% of the total population. Transportation within the area is by air. Transportation to other parts of the State is by air and the marine highway system connects Kodiak with the mainland. Kodiak is the principal city.

Two large military establishments are located in this area:

U. S. Naval Station, Kodiak U. S. Naval Station, Adak

The following information is provided for the Kodiak catchment area. Further information can be obtained from the priority tables.

a. Demographic Data

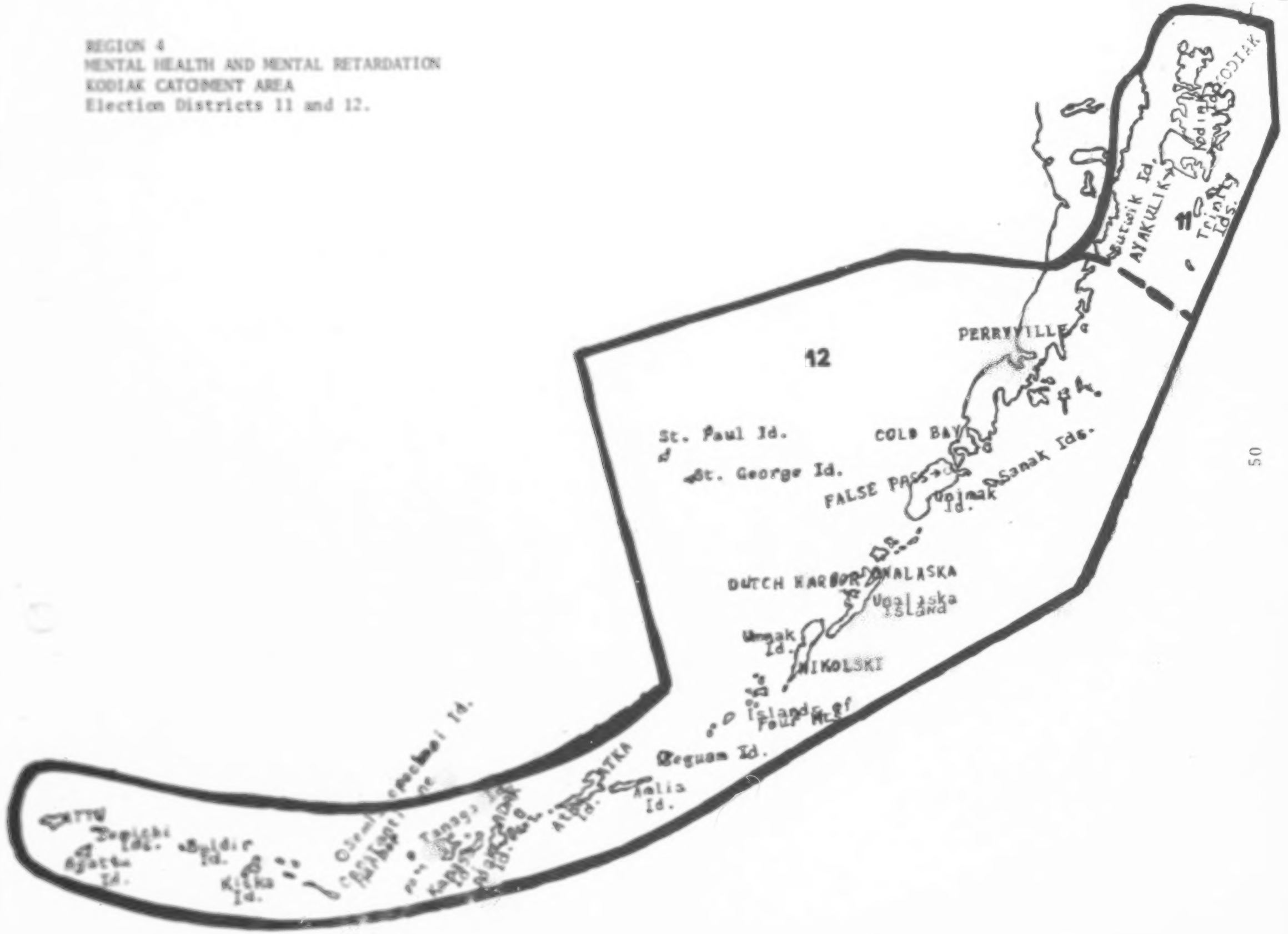
Population Figures by Age, Sex and Race-1960 Census

	All Ages	Under 19	19-44	45-64	65 and Over
All Classes	13,185	4,725	6,942	1,291	227
White Male	6,516	1,598	4,295	545	78
White Female	2,996	1,342	1,303	316	35
Nonwhite Male	2,116	938	838	260	80
Nonwhite Female	1,557	847	506	170	34

b. Socio-economic Data

Per capita income 1967 - $2,788
Unemployment rate 1968 - 7.9
Welfare payments U.S. Bureau of Indian Affairs 1967 - $25,693
Welfare payments Alaska Department of Health & Welfare 1967 - $101,556
Median school years completed 1960 census (male 25 years & older) - 11.7
Median school years completed 1960 census (female 25 years & older) - 11.3

REGION 4
MENTAL HEALTH AND MENTAL RETARDATION
KODIAK CATCHMENT AREA
Election Districts 11 and 12.



c. Indian Reservations

Located within this catchment area are the Karluk and Akutan Indian Reservations and the Amaknak Reserve. Please see Election District map.

d. Health Facilities

(1) Psychiatric

Alaska Psychiatric Institute - 225 beds. This facility is located in Anchorage and serves the entire State.

Southcentral Regional Mental Health Clinic. This facility is located in Anchorage and serves the entire catchment area.

(2) Mentally Retarded

Harborview Memorial Hospital - 150 beds. This facility is located in Valdez (often referred to as "Valdez") and serves the entire State.

(3) General Hospital

Kodiak Borough Hospital, Kodiak - 25 beds

(4) Public Health Service Hospitals

St. George Island Hospital - 6 beds
St. Paul Island Hospital - 7 beds

(5) Military Hospitals

U. S. Naval Station Hospital, Adak - 26 beds
U. S. Naval Station Hospital, Kodiak - 85 beds

e. Health Manpower (Practicing M.D.s)

aa. Private Practice

City	General Practice	General Surgery
Kodiak	2	1

bb. U. S. Public Health Service

St. Paul Island has one in general practice.

f. Health Manpower (P.H.N.s)

State of Alaska, Southcentral Region

Communities	P.H.N.s
Akutan, Atka, Belkofski, Cold Bay, False Pass, King Cove, Nikolski, Pauloff Harbor, Sand Point, Squaw Harbor, and Unalaska	1

St. George and St. Paul Islands (shared with 5 communties in the Anchorage Catchment Area)	1
Kodiak	1
Akhiok, Karluk, Ouzinkie, Larson Bay, Port Lions, Old Harbor	1
Chignik, Chignik Lagoon, Chignik Lake, Ivanoff Bay, Perryville, and Nelson Lagoon (shared with 8 communities from the Anchorage Catchment Area)	1

g. Other Services

American Red Cross, Alaska Heart Association, American Cancer Society, and Alcoholics Anonymous.

5. Catchment Area Five - Bethel (see map next page)

Catchment area five is located in southwestern Alaska and is made up of election districts 14 and 19. Geographically the area is flat except for the Ilivit Mountains, which extend into the northern part of district 19. The temperature drops to -30 degrees in the winter months. With the accompanying winds, a usual occurrence in Bethel, the chill factor is much lower. Annual precipitation is 18 inches.

The principal industry is commercial fishing, but most of it is seasonal and many of the people still rely on subsistence fishing and hunting to provide a poor living. Transportation within the area and to other parts of the State is by air. The 1968 population estimate for this area is 12,900. Bethel is the principal city.

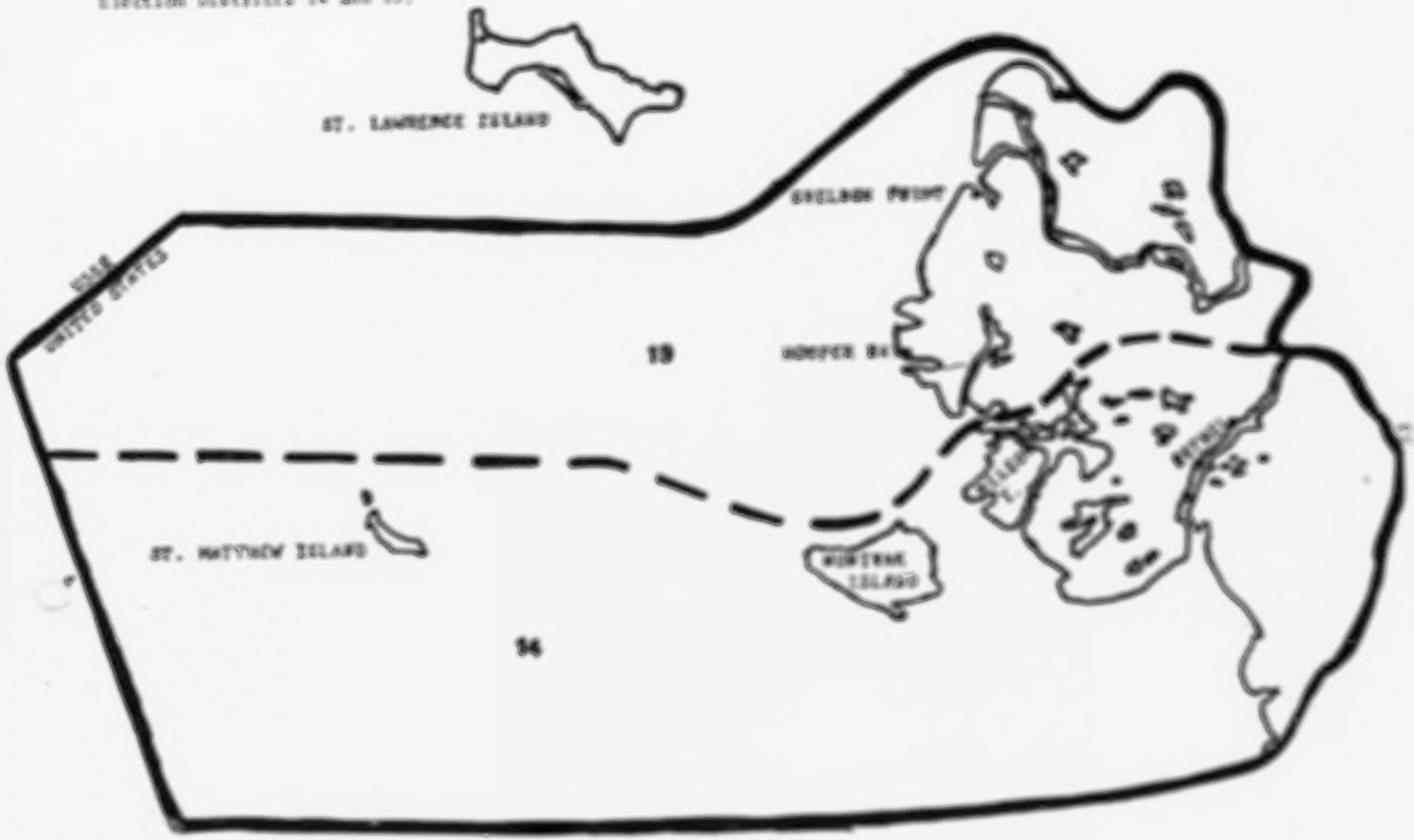
The following statistical information is provided for the Bethel catchment area. Further information can be obtained from the priority tables.

a. Demographic Data

Population Figures by Age, Sex and Race-1960 Census

	All Ages	Under 19	19-44	45-64	65 and Over
All Classes	8,665	4,743	2,873	825	224
White Male	455	92	288	59	16
White Female	226	75	116	30	5
Nonwhite Male	4,143	2,323	1,301	414	105
Nonwhite Female	3,841	2,253	1,168	322	98

REGION 5
MENTAL HEALTH AND MENTAL RETARDATION
BETHEL CATCHMENT AREA
Election Districts 14 and 19.



b. Socio-economic Data

Per capita income 1967 - $1461
Unemployment Rate 1968 - 11.2
Welfare payments U.S. Bureau of Indian Affairs 1967 - $169,069
Welfare payments Alaska Department of Health & Welfare 1967 - $161,161
Median school years completed 1960 census (male 25 years & older) - 2.9
Median school years completed 1960 census (female 25 years & older) - 2.5

c. Indian Reservations

The Nunstain Village and Akiak Indian Reserves are located in this catchment area. Location of these reserves are shown on the election district map.

d. Health Facilities

(1) Psychiatric

Alaska Psychiatric Institute - 225 beds. This facility is located in Anchorage and serves the entire State.

Southcentral Regional Mental Health Clinic. This facility is located in Anchorage and serves catchment areas three, four and five.

(2) Mentally Retarded

Alaskaview Memorial Hospital - 150 beds. This facility is located in Valdez (often referred to as "Valdez") and serves the entire State.

(3) General Hospitals

There are no general hospitals in this area.

(4) Public Health Service Facilities

Bethel Hospital - 42 beds

e. Health Manpower (Practicing M.D.s)

aa. Private Practice

There are no private practice M.D.s in this area.

bb. U.S. Public Health Service

City	General Practice	Pediatrics
Bethel	6	1

f. Medical Manpower (P.H.V.s)

State of Alaska, Southcentral Region

Communities	P.H.V.s
Akiak, Akiachak, Ewethlok, Nyac, and Tuluksak (shared with 9 communities in the Fairbanks Catchment Area)	1
Chefornak, Eek, Kipnuk, Kwigillingok, Nokoryuk, Newtok, Nightmute, Quinhagak, Tuntutuliak, Tununak	1
Chevak, Hooper Bay, Kasigluk, Napakiak, Napaskiak Nunapitchuk, Oscarville, Scammon Bay	1
Alakanuk, Chanelliak, Emmonak, Fortuna Ledge, Kotlik Area, Mountain Village, Pilot Station, Pitkas Point, Russian Mission (on Yukon), Sheldon Point, and St. Marys	1
Bethel	1
Goodnews Bay and Platinum (shared with 5 communities from Anchorage Catchment Area)	1

g. Other Services

Alaska Heart Association

h. Catchment Area Six - Fairbanks (see map next page)

Catchment area six is made up of election district 15 located in central Alaska and election district 16 located in northeastern Alaska. Geographically the area is mountainous with plateaus except along the Arctic coast. The temperature ranges from -80 in winter to 100 degrees in summer. The principal industries are oil, mining, and tourism. Transportation within the area and to other areas of the State is by highway and air. The 1968 population estimate for this area is 56,400. Fairbanks is the principal city. The North Slope oil discovery will likely distort that figure.

The public school system in Fairbanks is making rapid strides in providing special programs for the educable and trainable mentally retarded. The local association for the mentally retarded provides limited services for some of the pre-school mentally retarded.

REGION 6
MENTAL HEALTH AND MENTAL RETARDATION
FAIRBANKS CATCHMENT AREA
Election Districts 15 and 16.

The University of Alaska is located in College, Alaska, close to Fairbanks. Although small compared to other state universities, University of Alaska is making a steady growth and its programs and facilities are expanding. Their program of Arctic Research is considered foremost in the country.

Much of the land in this area between the scattered towns and villages is either tundra, which is swampy in summer or frozen in winter, or is mountainous. Building a road into the Northern regions has always been considered impossible, not only because of the enormous expense, but because of the sparse population. It was always suspected that the North Slope was rich in natural resources but the problems of power and transportation were considered too great. Now the huge oil strike has occurred and three major methods of transporting the oil have been planned. One is the famed "Super Tanker" (Manhattan) to ship oil through the Northwest passage, another a "Super Submarine" to navigate under the ice, and third a pipeline to Valdez. The State has built an ice road to the North Slope. Using this and air freight, the drilling machinery tools, and housing were moved to the site. The "ice road" is usable only in the winter. A permanent road as well as a railroad are being considered.

Military activity has been a major stimulus for Fairbanks development. Three large military installations are located in this area:

1. Fort Wainwright 2. Eielson Air Force Base 3. Fort Greely

The following statistical information is provided for the Fairbanks catchment area. Further information can be obtained from the polarity tables.

a. Demographic Data

Population Figures by Age, Sex and Race-1960 Census

	All Ages	Under 19	19-64	65-64	65 and Over
All Classes	51,629	20,915	28,159	3,536	519
White Male	25,393	8,249	14,820	2,067	862
White Female	19,765	7,334	7,334	1,434	715
Nonwhite Male	3,850	2,247	2,241	519	124
Nonwhite Female	2,621	2,123	1,422	330	139

b. Socio-economic Data

Per capita income 1967 - $2,[illegible]
Unemployment Rate 1968 - 6.[illegible]
Welfare payments U.S. Bureau of Indian Affairs 1967 - $334,[illegible]
Welfare payments Alaska Department of Health & Welfare 1967 - $751,[illegible]
Median school years completed 1960 census (male 25 years & older) - 9.1
Median school years completed 1960 census (female 25 years & older) - 7.1

c. Indian Reservations

The Venetie Chandalar Indian Reservation, Tanana Timber Reserve, Fort Yukon Reserve and the Tillin Reserve are located in the catchment area. Locations are shown on the election district map.

d. Health Facilities

(1) Psychiatric

Alaska Psychiatric Institute - 275 beds. This facility is located in Anchorage and serves the entire state.

Northern Regional Mental Health Clinic. This facility is located in Fairbanks and serves the Fairbanks and Nome catchment areas.

(2) Mentally Retarded

Northview Memorial Hospital - 150 beds. This facility is located in Valdez (often referred to as "Valdez") and serves the entire state.

(3) General Hospitals

Fairbanks Hospital - 67 beds

(4) Public Health Service Facilities

Tanana Hospital - 26 beds

(5) Military

Bassett Army Hospital, Fort Wainwright - 192 beds
U.S. Air Force Hospital, Eielson Air Force Base - 20 beds

e. Health Manpower (Practicing M.D.s)

aa. Private Practice

City	General Practice	Internal Medicine	O.B. Gyn.	Ophthalmology	Pediatrics	Surgery, General	Surgery, Orthopedic
Fairbanks	9	3	3	1	2	4	1
Tok	1						

bb. U.S. Public Health Service

Tanana - 3 in General Practice.

cc. U.S. Army - Bassett Army Hospital

General Practice - 2
Internal Medicine - 3
O.B. Gynecology - 1
Ophthalmology - 1
Otolaryngology - 1
Pathology - 1
Pediatrics - 2
Psychiatry - 1
Radiology - 1
Surgery, General - 3
Surgery, Orthopedic - 1

6. Health Manpower (P.H.N.s)

State of Alaska, Southcentral and Northern Region

Communities	P.H.N.s
Anial, Crooked Creek, Georgetown, Lower Kalskag, Upper Kalskag, Red Devil, Russian Mission (on Kuskokwim River), Stuetmute, and Stony River-Lime Village (shared with 5 communities from Bethel Catchment Area)	1
Dot Lake, Northway, Tanacross, Tetlin, and Tok Junction (shared with 12 communities from the Anchorage Catchment Area)	1
Anvik, Grayling, Holy Cross, McGrath, Medfra, Nikolai, Shageluk, Takotna, and Telida	1
Fairbanks Health Center	5
Allakaket, Arctic Village, Beaver, Bettles, Birch Creek, Canyon Village, Chalkyitsik, Ft. Yukon, Stevens Village, and Venetie (shared with Anaktuvuk Pass of Nome Catchment Area)	1
Central-Summit, Circle, Chena, Delta, Eagle, Healy, Minto, Nenana, Salcha Area, Tanacross and Tetlin	1
Galena, Hughes, Huslia, Kaltag, Koyukuk, Manley Hot Springs, Nulato, Rampart, Ruby, and Tanana	1
Gambell Island and Savoonga (shared with Barrow and Kotzebue of Nome Catchment Area)	2

8. Other Services

American Red Cross, Salvation Army, Presbyterian Hospitality House, Alaska Mental Health Association, Alaska Heart Association, Alaska State Elks Association, Cerebral Palsy Foundation Commission, Inc., Alaska Crippled Children's Association, American Cancer Society, Alcoholics Anonymous, National Foundation, and Arctic Association for Retarded Children (mentioned above)

7. Catchment Area Seven - Nome (see map next page)

Catchment area seven is located in northern Alaska and is made up of election districts 17 and 18. Geographically the area is mountainous except for a large coastal plain which extends across the northern part along the Arctic coast. The climate at Nome in the southwest part of the area is a harsh sub-arctic climate while the northern part of the area has an arctic climate. The annual average temperature at Nome is 32.6 degrees. Annual average total precipitation is 17.88 inches. A subsistence hunting and fishing economy prevails with the majority of employed persons working for government, public utilities and various trades. Transportation within the area and to other parts of the state is by air. The 1968 population estimate for this area is 13,700. Nome is the principal city.

REGION 7
MENTAL HEALTH AND MENTAL RETARDATION
HOME CATCHMENT AREA
Election Districts 17 and 18.

For some time now, oil and natural gas has been extracted on the U.S. Naval Reserve near Barrow, and it is interesting to see the crude native houses in Barrow, each with a gas pipe and electric power lines connected.

The huge oil strike on the North Slope is affecting this area too, but to a lesser extent as most activity flows through Valdez. However, it now appears that oil drilling will occur off shore in the Bering Sea, and possibly Yukon Sound.

The following statistical information is provided for the Yukon catchment area. Further information can be obtained from the priority tables.

a. Demographic Data

Population Figures by Age, Sex and Race-1960 Census

	All Ages	Under 19	19-44	45-64	65 and Over
All Classes	11,744	5,852	4,159	1,385	415
White Male	1,733	282	1,107	291	53
White Female	936	209	241	191	50
Nonwhite Male	4,852	2,727	1,482	543	172
Nonwhite Female	4,863	2,435	1,294	660	174

b. Socio-economic Data

Per capita income 1967 - $1,842
Unemployment Rate 1968 - 13.0
Welfare payments U.S. Bureau of Indian Affairs 1967 - $157,927
Welfare payments Alaska Department of Health & Welfare 1967 - $709,157
Median school years completed 1960 census (male 25 years & older) - 7.7
Median school years completed 1960 census (female 25 years & older) - 5.3

c. Indian Reservations

The following Indian reservations and reserves are located in this catchment area:

Unalakleet Reservation
St. Lawrence Island Reindeer Reserve
Shaktoolik Reservation
Koyuk Reservation
Wainwright Reserve
Cape Denbigh Reindeer Reserve
Wales Reservation
White Mountain Reservation
Kobuk River Reserve

Please see election district map.

d. Health Facilities

(1) Psychiatric

Alaska Psychiatric Institute - 225 beds. This facility is located in Anchorage and serves the entire State.

Northern Regional Mental Health Clinic. This facility is located in Fairbanks and serves the Fairbanks and Nome Catchment Areas.

(2) Mentally Retarded

Maplewview Memorial Hospital - 150 beds. This facility is located in Valdez (often referred to as "Valdez") and serves the native people.

(3) General Hospitals

Maynard-Mahnugali Hospital, Nome - 24 beds

(4) Public Health Service Facilities

Kotzebue Hospital - 30 beds
Barrow Hospital - 16 beds

e. Medical Manpower (Practicing M.D.s)

aa. Private Practice

Nome has one in General Surgery.

bb. U. S. Public Health Service

City	General Practice
Barrow	2
Kotzebue	4

f. Medical Manpower (P.H.N.s)

State of Alaska, Northern Region

Communities	P.H.N.s
Anaktuvuk Pass (shared with 10 communities from Fairbanks Catchment Area)	1
Ambler, Kiana, Kobuk, Noorvik, Selawik, and Shungnak	2 (1 of whom is with Headstart)
Nome Health Center	1
Barrow and Wainwright (shared with Barter Island and Kaktovik of the Fairbanks Catchment Area)	
Gayuk, Shaktoolik, Stebbins, St. Michael, and Unalakleet	2
Candwell, North East Cape, and Savoonga	1

THERE ARE CURRENTLY FIFTEEN COMMUNITIES IN THIS CATCHMENT AREA WHICH DO NOT HAVE THEIR NORMAL P.H.N. COVERAGE. (An absence of 2 P.H.N.s)

g. Other Services

American Red Cross, American Cancer Society, and National Foundation.

C. Definitions

1. Services

The mentally retarded require an array of services that provide a "continuum of care" or "spectrum of opportunity" for all levels of retardation and for all age groups.

To achieve a continuum of care requires an overall program of direct services. All services shall be correlated to provide maximum efficiency and use of available financial and personnel resources to insure full coverage of needs of the retarded.

a. Diagnostic Services

Coordinated medical, psychological, and social services, supplemented where appropriate by nursing, educational, or vocational services and carried out under the supervision of personnel qualified to: (1) diagnose, appraise, and evaluate mental retardation and associated disabilities and the strengths, skills, abilities, and potentials for improvement of the individual; (2) determine the needs of the individual and his family; (3) develop recommendations for a specific plan of service to be provided with necessary counseling to carry out recommendations; and (4) where indicated, periodically reassess progress of the individual.

An adequate and thorough diagnosis and evaluation of all retarded persons is essential to the proper planning of individual programs to meet particular and specific needs. Both short-term and long-term planning for treatment, training, education, and personal care or supervision of the individual and counseling of his parents is dependent upon the quality of diagnosis and evaluation services provided for him. Hence, diagnostic and evaluation services are the keystone to the development of a complete array of services in any community or region.

Mental Retardation is frequently complicated by problems of associated physical disabilities, emotional disturbances, sensory defects, and the like. The existence of these correlative conditions emphasizes the need for comprehensive diagnosis and evaluation prior to the development of individual services for treatment, education, training, personal care services, or sheltered employment.

b. Treatment Services

Services under medical direction and supervision providing specialized medical, psychiatric, neurological, or surgical treatment, including, where appropriate, dental therapy, physical therapy, occupational therapy, speech and hearing therapy, or other related therapies which provide for improvement in effective physical, psychological, or social functioning of the individual.

c. Educational Services

Services, under the direction and supervision of teachers qualified in special education, which provide a curriculum of instruction for pre-school children, for school-age children or for the mentally retarded beyond school age.

The basic functions of educational programs for children of pre-school age are to develop basic self help skills such as dressing and grooming, develop prevocational skills, provide socialization and group training, and promote environmental enrichment for the culturally deprived to improve intellectual experience and motivation. Educational services for the retarded of school age encompass a curriculum of instruction for those unable to keep abreast of a normal public school program. The content of such a curriculum must relate to the capacities of the individuals whom it is to serve.

Vocational training includes the following: Vocational evaluation, counseling, systematic planned instruction for sheltered or competitive employment, placement and followup services. All these services are to be carried out under the supervision of personnel qualified to direct them.

d. Training Services

Services which provide (1) training in self-help and motor skills, (2) training in activities of daily living, (3) training in useful occupational skills, (4) opportunities for personality development and social skills or (5) experiences conducive to social development, and which are carried out under the supervision of personnel qualified to direct these services.

This broad definition of training services also includes group activity services, as well as group home and halfway house services.

Group activity services are defined as: Coordinated programs of diversified activities providing opportunities for individual learning and participation including recreational activities.

Group home or halfway house services are defined as: Supervised housing arrangements which may include counseling and group activities for small groups of mentally retarded individuals capable of relatively independent living or for individuals needing opportunities to become oriented to community life.

Training services for those in the lower levels of retardation should provide opportunities for the development of behavior patterns, self-care skills, social skills, health habits and attitudes, money management, and many others. Training may be provided on an individual or group basis.

Training programs must be compatible with the present development levels, learning characteristics, and potentials for future development of the retardates involved. For the younger retarded person, training programs usually emphasize self-help, basic communication, and interpersonal skills. For the older or more capable individual, training programs will generally stress activities which provide opportunities to acquire skills enhancing participation in family, community and economic life. Include programs for adults who have completed various types of educational programs available during the school-age years but who are too handicapped to be acceptable in a vocational training or sheltered workshop program.

e. Custodial Services (Personal Care)

Services which provide personal care for any part of the day or 24 hours a day, including, where needed, health services supervised by qualified medical or nursing personnel. Personal care covers food, shelter, hygienic attention, and clothing for 24 hours a day or any part thereof.

Personal care services involve much more than programs designed solely to furnish food, clothing, and shelter. These services should only be maintained where treatment, education, and/or training services are provided within the same facility in order to bring the individuals involved to a higher level of function.

f. Sheltered Workshop Services

Services in a facility which provides or will provide a program of paid work involving: (1) work evaluation; (2) work adjustment training; (3) occupational skill training; (4) transitional or extended employment; and (5) placement; and carried out under the supervision of personnel qualified to direct these activities.

Sheltered workshop services have two major aspects: transitional employment and extended employment. In transitional employment, the major goal is eventual placement in community employment. Such a program gives considerable emphasis to training, evaluation, and placement programs as well as to actual employment activities. In the extended employment program, the emphasis is upon a broad range of work activities for those who cannot function satisfactorily in competitive employment.

There are certain advantages in providing the mentally retarded with sheltered workshop services in programs which include other handicapped individuals. For some of the mentally retarded, such programs can permit valuable opportunities for socialization experiences and widen the range of job contacts that can be fulfilled. These benefits can be realized, however, only if the staff of the multi-purpose workshop recognizes the special needs of the retarded, particularly the longer training time frequently required.

B. Facilities

a. Diagnostic and Evaluation Facility

A facility providing only diagnostic services as defined in (1) above.

b. Day Facility

A facility open for care and treatment of the mentally retarded on less than a 24-hour a day basis, providing diagnosis (and evaluation), treatment, education, training, custodial care (personal care) or sheltered workshop services.

c. Residential Facility

A facility open for care and treatment of the mentally retarded on a 24-hour a day basis, providing diagnosis (and evaluation), treatment, education, training, custodial care (personal care) or sheltered workshop services.

D. Other Handicapping Conditions

a. Hearing impairment - a partial to total loss of hearing bradley to a handicap of varying degrees.

b. Visual impairment - a loss of vision which has any one of the following characteristics:

(1) Visual acuity is less than 20/70 in the better eye with best correction.

(2) A visual field restriction which subtends an angle of 20° or less in the better eye.

(3) An eye condition of a progressive nature which is likely to lead to blindness.

c. Speech impairment - any difficulty or concern with a person's articulation of sounds, rhythm of speech and/or voice quality.

d. Language impairment - insufficient development of, or a breakdown in, the ability to use in a meaningful manner either spoken or written words, or other means of receiving and/or expressing words or symbols.

e. Convulsive disorder - any of a group of symptoms characterized by sudden, involuntary, paroxysmal episodes which tend to occur sporadically from time to time. These episodes are also sometimes called epileptic spells, attacks, fits, or seizures.

f. Motor impairment - an interference with the integrated performance of normal body movements.

g. Behavior disorder - a significant difficulty in adapting socially, emotionally or socially to one's environment.

3. Inventory of Existing Services and Facilities

Information has been obtained concerning every known facility serving the Mentally Retarded in the State of Alaska. This includes public and private schools as well as, public and private agencies.

4. Requesting Inventory Information

Inventory data is recorded on SDS:DSA:DMD:CB Tentative Form A, SDS:DSA:DMD:CB Tentative Form B, SDS:DSA: - 69-1, and SDS:DSA: - 69-2. Please read "Explanation of Inventories" immediately preceding the forms.

COMPLAINTS OF INCONSISTENCIES

Instructions appearing in the federal guidelines for the state plan for Construction of Mental Retardation Facilities are inconsistent with the information requested on the face of the form or appear inconsistent with other instructions. To avoid misunderstanding the following interpretations have been made:

Interpretation	Reason
SDI:DSA:DMR:CB Footnotes from A Questions number 9 and 10 reflect total numbers over the last 12 months.	The questions indicate capacity; the guideline instructions for form A, indicate capacity; but the guidelines for form B, say that a total number over the last 12 months (item 8a) must agree with form A, item 10. Therefore item 9 must also be a total number over the last 12 months.
SDI:DSA: o 46-2 All numbers reflect the total numbers over the last 12 months.	The face of the form asks for average daily case loads for 46-4g and 5b-5g. The guideline instructions repeat this request. Still, the guideline instructions insist that 4f (a average daily case load) equal 8a (total number over the last 12 months). The same comment applies to 5f and 5a. Next, the instructions on the back of SDI:DSA: o46-2 say that 4b-4g and 5b-5g should be the total number over the last 12 months. They repeat that 4f should equal 8a and that 5f should equal 5a.

For further clarification, the following statements are made:

The Alaska Psychiatric Institute and Mathoview Memorial Hospital serve the entire State. Nonetheless, to save confusion, the numbers served are recorded only in the area where the facilities are located. Under Determination of Priorities, the numbers of Mentally Retarded individuals per service area (only information available) will be utilized.

The three State Mental Health Clinics serve more than one area. Nonetheless, to save confusion, the numbers served are recorded only in the area where the facilities are located. Under Determination of Priorities, the numbers of Mentally Retarded individuals (main information available) will be utilized.

The State of Alaska now has 49 patients placed at Haven Acres, Oregon. These numbers do not appear in the inventories.

STATE PLAN

COMMUNITY MENTAL RETARDATION FACILITIES CONSTRUCTION PROGRAM

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STATE PLAN

COMMUNITY MENTAL RETARDATION FACILITIES CONSTRUCTION PROGRAM

SECTION I - GENERAL DATA

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)
	Location							Mentally Retarded Persons Served in Facility														
								Level of Retardation						Age Groups								
Area No.	City or Town	Borough	Name of Facility	Type of Facility (Code)	Type of Ownership (Public or Private) (Code)	Total Number of Persons Served	Total	Profound	Severe	Moderate	Mild	Borderline or Not Classified	0-4	5-9	10-14	15-19	20-64	65 & Over	Services Provided (Code)
1	Anchorage	Greater Anchorage	Alaska Crippled Children and Adult Treatment Center	O	A	700	234	167	30	25	11	-	134	29	100				A,C,D & F
	Anchorage	Greater Anchorage	Association for Retarded Children of Anchorage (Private School)	P	A	29	29	5	7	14	4	-	14	15					
	Anchorage	Greater Anchorage	Child Study Center	G	B	134	62	20	25	25	5	1	23	40	17				
	Anchorage	Greater Anchorage	Hope Cottage	G	A	26	20	2	5	9	4	-	1	9	6				
	Anchorage	Greater Anchorage	Public Schools	P	B	30,351	270	520	50					270	100				
	Anchorage	Greater Anchorage	Tom Thumb School (Private)	P	A	525	2	2						2					
	Anchorage	Greater Anchorage	Alaska Psychiatric Institute	G	B	587	102	12	37	34	17	2	-	11	36	48	7	-	C,D,E & G
	Anchorage	Greater Anchorage	South-Central State Mental Health Clinic	G	B	1,932	60	27	20	8	5	-	4	32	18	5	1	-	C & G

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COMMUNITY MENTAL RETARDATION FACILITIES CONSTRUCTION PROGRAM

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RECIPIENT - GENERAL DATA

AREA NO.	LOCATION: NAME OF PLACE	LOCATION: Borough	NAME OF FACILITY	TYPE OF FACILITY CODE	TYPE OF OWNERSHIP OF FACILITY CODE	TOTAL NUMBER OF PERSONS SERVED	STATUS	MENTALLY RETARDED PERSONS SERVED IN FACILITY: NUMBER OF RETARDATIONS: [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	AGE GROUPS: [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
(1)	(2a)	(2b)	(3)	(4)	(5)	(6)	(7)	(8a)	(8b)	(8c)	(8d)	(8e)	(9a)	(9b)	(9c)	(9d)	(9e)	(9f)	(10)
3	[illegible]	-	Public School	P	0	350	0	0						0					
	Bensal	Bensal Pensive-nelle	Public School	P	0	4,300	0	0						0					
	Palmer	Metropolis-Overview	Public School	P	0	1,200	0	0						0					
	Valdez	-	*Northeastern Memorial Hospital	C	0	261	100	12	52	36	10	0	-	7	24	10	12	0	0,0,C, 0,0,P 0 0
	Valdez	-	Public School	P	0	267	24	24						12	12				
	*Alaska Psychiatric Institute & Northeastern Memorial Hospital Across the Cotton Bridge. **Between Lake Three, Four and Five.																		
				31															24,18
				18															32,30
				67	00														52,37
			Area Totals Three	33	00	10,170	1,500	600	200	100	40	0	300	900	2,100	100	24	0	0 30

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COMMUNITY MENTAL RETARDATION FACILITIES CONSTRUCTION PROGRAM

INVENTORY - GENERAL DATA

1970	Alaska

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Area	City or Town	Borough	Name of Facility	Type of Facility (1)	Type of Ownership of Facility (2)	Total Number of Persons Served	Total	Mentally Retarded Persons Served in Facility: Level of Retardation: Profoundly Retarded (IQ 0-19)	Severely Retarded (IQ 20-34)	Moderately Retarded (IQ 35-49)	Mildly Retarded (IQ 50-69)	Borderline (IQ 70-79)	Age Groups: 0-5 Years	6-12 Years	13-17 Years	18-21 Years	22-64 Years	65 Years and Over	Remarks (Including Number of Persons Served in Each Category)
1	2a	2b	3a	3	4	5	6	7a	7b	7c	7d	7e	8a	8b	8c	8d	8e	8f	9
5	Bethel	-	Public Schools	F	B	849	30	25	5					25	5				
	Area Totals Five			F	B	849	30	25	5					25	5				

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STATE PLAN
COMMUNITY MENTAL RETARDATION FACILITIES CONSTRUCTION PROGRAM

FORM APPROVED
BUREAU OF THE BUDGET
NO. 68-R0110

FISCAL YEAR	STATE
1970	Alaska

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INVENTORY - GENERAL DATA

AREA	LOCATION: CITY OR TOWN	LOCATION: Borough	NAME OF FACILITY	TYPE OF FACILITY (CODE)	TYPE OF OWNERSHIP OF FACILITY (CODE)	TOTAL NUMBER OF PERSONS SERVED	MENTALLY RETARDED PERSONS SERVED IN FACILITY: TOTAL	LEVEL OF RETARDATION: BORDERLINE (IQ 68-83)	LEVEL OF RETARDATION: MILD (IQ 52-67)	LEVEL OF RETARDATION: MODERATE (IQ 36-51)	LEVEL OF RETARDATION: SEVERE (IQ 20-35)	LEVEL OF RETARDATION: PROFOUND (IQ 19 OR LESS)	AGE GROUPING: 5 & UNDER	AGE GROUPING: 6-12 YEARS	AGE GROUPING: 13-20 YEARS	AGE GROUPING: 21-39 YEARS	AGE GROUPING: 40-64 YEARS	AGE GROUPING: 65 YEARS AND OVER	SERVICES FOR MENTALLY RETARDED PROVIDED IN FACILITY (CODE)
1	2a	2b	2c	3	4	5	6	7a	7b	7c	7d	7e	8a	8b	8c	8d	8e	8f	9
6	Fairbanks	North Star	Arctic Association for Retarded Children (Private School)	P	A	14	14	14					14						
	Fairbanks	North Star	Eielson School	F	B	1,957	10	10						10					
	Fairbanks	North Star	*Northern Area State Mental Health Clinic	S	B	100	54	10	8	5	5	1	19	10	4				E & G
	Fairbanks	North Star	Public Schools	F	B	8,200	70	60	10				64	6					
	Fairbanks	North Star	Hope Center	G	A	12	12	6	6				7	5					
	Nenana	-	Public Schools	F	B	210	6	6					6						
	*Nenana Area Sts and Nenana.			SF 19	2A														
			Area Totals Sts	31	48	10,983	166	116	24	5	5	1	15	106	23	4			E & G

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COMMUNITY MENTAL RETARDATION FACILITIES CONSTRUCTION PROGRAM

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FISCAL YEAR	STATE
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SECTION I - GENERAL DATA

CODE	LOCATION: CITY OR TOWN	LOCATION: County	NAME OF FACILITY	TYPE OF FACILITY (CODE)	TYPE OF OWNERSHIP OF FACILITY (CODE)	TOTAL NUMBER OF PERSONS SERVED	TOTAL STAFF	ACTUALLY RETARDED PERSONS SERVED IN FACILITY: LEVEL OF RETARDATION: SEVERELY RETARDED (IQ 0-19)	LEVEL OF RETARDATION: MODERATELY RETARDED (IQ 20-34)	LEVEL OF RETARDATION: MILDLY RETARDED (IQ 35-49)	LEVEL OF RETARDATION: BORDERLINE (IQ 50-69)	LEVEL OF RETARDATION: PERSONS OF NORMAL INTELLIGENCE (IQ 70 OR ABOVE)	AGE GROUPING: 0-5 YEARS	AGE GROUPING: 6-14 YEARS	AGE GROUPING: 15-19 YEARS	AGE GROUPING: 20-34 YEARS	AGE GROUPING: 35-64 YEARS	AGE GROUPING: 65 YEARS AND OVER	ACTUALLY RETARDED PERSONS SERVED IN FACILITY: CODE FOR PRIMARY DISABILITY (IF MORE THAN ONE)
1	2a	2b	3	4	5	6	7	8a	8b	8c	8d	8e	9a	9b	9c	9d	9e	9f	9
7	Nome	-	Public Schools	P	D	760	11	11						11					
			Area Totals Seven	1P	1D	760	11	11						11					
KEY				22P 3D 5C	9A 22D														20,18 3C,3D 18,9P
			STATE TOTAL	32		66,240	1,680	956	283	165	68	8	261	770	336	110	200	5	5C

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(SMALL/NOT MENTAL RETARDATION FACILITY) CONSTRUCTION PROGRAM

INVENTORY - SERVICES DATA FOR MENTALLY RETARDED PERSONS SERVED ONLY

AREA	CITY OR TOWN	Borough	NAME OF FACILITY	PUBLIC OR PRIVATE	TOTAL NUMBER SERVED	DAY FACILITY: AVERAGE DAILY CASE LOAD IN SERVICES						RESIDENTIAL FACILITY: AVERAGE DAILY CASE LOAD IN SERVICES							
						DIAGNOSIS & EVALUATION	TREATMENT	EDUCATION	TRAINING	PERSONAL CARE	SHELTERED EMPLOYMENT	TOTAL NUMBER SERVED	DIAGNOSIS & EVALUATION	TREATMENT	EDUCATION	TRAINING	DAILY TRANSPORT	SHELTERED EMPLOYMENT
1	2a	2b	3a	3	4a	4b	4c	4d	4e	4f	4g	4h	5a	5b	5c	5d	5e	5f	5g
1	Ketchikan	Gateway	Public Schools		80			70	10	80									
	Petersburg	-	Public Schools		1			1		1									

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[illegible] - SERVICES DATA FOR MENTALLY RETARDED PERSONS SERVED ONLY

[illegible]																							
[illegible]	[illegible]																						

STATE PLAN
COMMUNITY MENTAL RETARDATION FACILITIES CONSTRUCTION PROGRAM

FISCAL YEAR 1970 | STATE Alaska

SUPPLEMENT - SERVICES DATA FOR MENTALLY RETARDED PERSONS SERVED ONLY

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AREA NO.	LOCATION: City or Town	LOCATION: Borough	NAME OF FACILITY	CONSTRUCTION COMPLETED (Yes)	TOTAL NUMBER SERVED	DAY FACILITY: AVERAGE DAILY CASE LOAD IN SERVICE: Ambulatory Retarded	DAY FACILITY: AVERAGE DAILY CASE LOAD IN SERVICE: Non-Ambulatory	DAY FACILITY: AVERAGE DAILY CASE LOAD IN SERVICE: Emotionally Disturbed	DAY FACILITY: AVERAGE DAILY CASE LOAD IN SERVICE: Psychotic	DAY FACILITY: AVERAGE DAILY CASE LOAD IN SERVICE: Other Handicapped	DAY FACILITY: AVERAGE DAILY CASE LOAD IN SERVICE: Total	TOTAL NUMBER SERVED	RESIDENTIAL FACILITY: AVERAGE DAILY CASE LOAD IN SERVICE: Ambulatory Retarded	RESIDENTIAL FACILITY: AVERAGE DAILY CASE LOAD IN SERVICE: Non-Ambulatory	RESIDENTIAL FACILITY: AVERAGE DAILY CASE LOAD IN SERVICE: Emotionally Disturbed	RESIDENTIAL FACILITY: AVERAGE DAILY CASE LOAD IN SERVICE: Psychotic	RESIDENTIAL FACILITY: AVERAGE DAILY CASE LOAD IN SERVICE: Other Handicapped	RESIDENTIAL FACILITY: AVERAGE DAILY CASE LOAD IN SERVICE: Total
1	2a	2b	2c	3	4a	4b	4c	4d	4e	4f	4g	5a	5b	5c	5d	5e	5f	5g	5h
3	Anchorage	Greater Anchorage	Alaska Crippled Children and Adult Treatment Center		258	136	117	54	48	234	-								
	Anchorage	Greater Anchorage	Association for Retarded Children of Anchorage (Private School)		28			6	17	28									
	Anchorage	Greater Anchorage	Child Study Center	62															
	Anchorage	Greater Anchorage	Hope Cottage		29			6	11	29									
	Anchorage	Greater Anchorage	Public Schools		570			520	50	570									
	Anchorage	Greater Anchorage	Tom Thumb School (Private)		2			2		2									
	Anchorage	Greater Anchorage	*Alaska Psychiatric Institute									102	-	102	21	80	102	-	
	Anchorage	Greater Anchorage	**South-Central State Mental Health Clinic		60	60	60	27	20	60									
	Billingham	-	Public Schools		5			5		5									

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[illegible] 1972 [illegible]

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INVENTORY - SERVICES DATA FOR MENTALLY RETARDED PERSONS SERVED ONLY

Area	City or Town	Borough	Name of Facility	Proposed Facility: Total Number Served	Proposed Facility: Total Number Served	Residential Facility: Total Number Served	Residential Facility: Average Daily Case Load in Service: Diagnosis & Evaluation	Residential Facility: Treatment	Residential Facility: Habilitation	Residential Facility: Training	Residential Facility: Personal Care	Residential Facility: Sheltered Employment	Non-Residential Facility: Total Number Served	Non-Residential Facility: Average Daily Case Load in Service: Diagnosis & Evaluation	Non-Residential Facility: Treatment	Non-Residential Facility: Habilitation	Non-Residential Facility: Training	Non-Residential Facility: Sheltered Employment	Non-Residential Facility: Other Services
1	2a	2b	2c	3	4a	4b	4c	4d	4e	4f	4g	5a	5b	5c	5d	5e	5f	5g
3	Kenai	Kenai Peninsula	Public Schools		2			2		2								
	Palmer	Matanuska Susitna	Public Schools		8			8		8								
	Valdez	-	*Hutchview Memorial Hospital									270	-	270	30	62	270	-
	Valdez	-	Public Schools		20			20		20								
			Area Totals Three	62	750	290	212	450	162	750		290		290	51	342	290	

*Alaska Psychiatric Institute and Hutchview Memorial Hospital.
**Service Areas Three, Four and Five.

1	2a	2b	3	4	5a	6a	6b	6c	6d	6e	6f	7a	8a	8b	8c	8d	8e	8f	8g
1	Suburb	Suburb Suburb	Public School		1			1		1									
			Area Total:		1			1		1									

STATE PLAN

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[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1	2a	2b	2c	3	4a	4b	4c	4d	4e	4f	4g	5a	5b	5c	5d	5e	5f	5g
6	Fairbanks	North Star	Arctic Association for Retarded Children (Private School)		14			14		14								
	Fairbanks	North Star	Elsie Sem School		18			18		18								
	Fairbanks	North Star	*Northern Area State Mental Health Clinic		34	34	34	18	8	34								
	Fairbanks	North Star	Public Schools		70			60	10	70								
	Fairbanks	North Star	Hope Center		12			6	6	12								
	Nenana	-	Public Schools		6			6		6								
			*Includes Admin Site and Annex.															
			Area Totals Six		185	34	34	116	24	160								

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COMMUNITY MENTAL RETARDATION FACILITIES CONSTRUCTION PROGRAM

PROGRAMMING DATA REPORT

CODE	LOCATION: CITY OR COUNTY	Borough	SERVICES TO BE OFFERED (Check)						LEVEL OF RETARDATION TO BE SERVED (Check)					AGE GROUPS TO BE SERVED (Check)						POPULATION OF CATCHMENT AREA	POPULATION OF AREA	CODE: CHECK IF LOCATION OF BUILDING IS TO BE DETERMINED BY HEW REGIONAL OFFICE
1	2a	2b	3a	3b	3c	3d	3e	3f	4a	4b	4c	4d	4e	5a	5b	5c	5d	5e	5f	6	7	8
2	Anchorage	Greater Anchorage	P	I		X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	100	
	Valdez	-	P	I		X	X	X	X	X	X	X	X	X	X	X	X	X	X	20	100	

Alaska does not have government facilities for all Mentally Retarded individuals in need of service.

Please see: Levels of the Planning Area and Delineation of Need for Services for details concerning number of Mentally Retarded and those receiving service.

	STATE TOTAL		2P	2-I																	20	200	

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F. Needs of Planning Area

Programmed Mentally Retarded facilities are inventoried on Form SRS-MRA - 49-3. At this time only two structures are planned within the next four years - both rehabilitation facilities. Alaska does not have programmed facilities for all Mentally Retarded individuals in need of services. The development of such programming has been hampered by lack of local funds, minimal program direction, and poor identification of need. Alaska is still very young in development of Mentally Retarded Services. Thus, far, the majority of services are provided by the state government. State officials and the Comprehensive Health Advisory Council, are trying to stimulate local planning for mental retardation facilities. Data-gathering has begun on a more precise basis. The possibility of obtaining local matching money is increasing, though subsidies may be required. When communities can visualize some promise of resolution of these constraints, the purpose of planning will carry more meaning.

G. Estimation of Need for Services

Currently, the only available measurement of Mental Retardation in Alaska is the number representing the individuals receiving service. Therefore, the number of mentally retarded in Alaska will be determined by subtracting the number of mentally retarded in Alaska's estimated population by two (2) percent of that population. Most authorities feel that two percent would be a minimum number for Alaska.

Alaska's estimated 1968 population	=	284,000
Two percent of this (Mentally Retarded)	=	5,680
Number of Mentally Retarded receiving service	=	1,480 (Some Duplication Likely)
Unmet Need		4,200

H. Determination of Priorities

The relative need for mentally retarded services within Alaska's seven catchment areas is calculated according to factors considered below.

1. Determination of Priorities Among Areas

a. Need for Services and Facilities Factor

In determining need for services within a catchment area, two main approaches can be made. One is a consideration of numbers, and the other is consideration of relative need. A ratio of need within a catchment area to need within the state is, of course, a pure numbers consideration. This gives emphasis areas with the greatest number of need and de-emphasis areas with smaller need but perhaps with no current method of solving their need. Both numbers need and relative need require attention. Therefore, two charts are given below and each is given equal magnitude within the ranking. This is subject to federal interpretation.

(1). Need Consideration by Numbers

Area Numbers & Name	M.R. Individuals Receiving Services*	# M.R. (2% '68 Pop.)	Unmet Need	Need State Need	Unmet Need State Unmet Need	Rank
Ketchikan - 1	95	394	299	0.075	0.071	4
Juneau - 2	197	504	307	0.09	0.070	5
Anchorage - 3	928	2,784	1,856	0.49	0.44	1
Kodiak - 4	23	374	351	0.066	0.08	5
Bethel - 5	47	258	211	0.045	0.05	7
Fairbanks - 6	174	1,092	918	0.19	0.22	2
Nome - 7	16	274	258	0.048	0.06	6
TOTALS	1,480	5,680	4,200	-	-	-

(2). Relative Need

Area Numbers & Name	M.R. Individuals Receiving Service*	# M.R. (2% '68 Pop.)	Unmet Need	Ratio of Unmet Need to Area M.R.	Rank
Ketchikan - 1	95	394	299	0.76	5
Juneau - 2	197	504	307	0.61	7
Anchorage - 3	928	2,784	1,856	0.67	6
Kodiak - 4	23	374	351	0.938	2
Bethel - 5	47	258	211	0.82	4
Fairbanks - 6	174	1,092	918	0.84	3
Nome - 7	16	274	258	0.942	1
TOTALS	1,480	5,680	4,200	-	-

*The '69 patients now at Haven Acres, Oregon are not counted as sending individuals out-of-state merely indicates a need within the state.

b. Economic Factors

(1). Percent of Families with Low Income

Area Numbers & Names	Total Families	Families Income Less Than $5,000	% Income Less Than $5,000	Ratio % Income - $5,000 in Area / % Income - $5,000 in State	Rank
Ketchikan - 1	3,529	225	6.3	1.12	4
Juneau - 2	6,082	185	4.5	0.80	7
Anchorage - 3	23,574	1,104	4.7	0.84	6
Kodiak - 4	2,140	162	7.6	1.36	3
Bethel - 5	1,458	204	14	2.5	1
Fairbanks - 6	10,174	518	5.1	0.91	5
Nome - 7	1,631	236	11.6	2.11	2
STATE	46,787	2,612	5.6	-	-

(2). Per Capita Income

Area Numbers & Names	Total Families	Per Capita Income	Ratio Per Capita Income in Area / Per Capita Income in State	Rank
Ketchikan - 1	3,529	2,535	0.91	3
Juneau - 2	6,082	2,919	1.05	6
Anchorage - 3	23,574	3,125	1.13	7
Kodiak - 4	2,140	2,788	1.006	4
Bethel - 5	1,458	541	0.19	1
Fairbanks - 6	10,174	2,896	1.04	5
Nome - 7	1,631	1,242	0.45	2
STATE	46,787	2,772	-	-

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c. Education Factor
Median School Years Completed

Area Numbers & Name	Median School Years Completed	Ratio: Median School Years Completed in Area / Median School Years Completed in State	Rank
Ketchikan - 1	11.1	1.19	5
Juneau - 2	12.0	1.29	7
Anchorage - 3	11.0	1.18	4
Kodiak - 4	11.3	1.22	6
Bethel - 5	2.2	0.24	1
Fairbanks - 6	7.5	0.81	3
Nome - 7	5.7	0.61	2
STATE	9.3	-	-

d. Health Factor
Rate of Infant Mortality

Area Numbers & Name	Infant Mortality*	Ratio: Rate of Infant Mortality in Area / Rate of Infant Mortality in State	Rank
Ketchikan - 1	19.95	0.68	5
Juneau - 2	17.8	0.605	7
Anchorage - 3	21.0	0.71	4
Kodiak - 4	19.5	0.66	6
Bethel - 5	81.2	2.76	1
Fairbanks - 6	33.2	1.13	3
Nome - 7	73.2	2.49	2
STATE	29.4	-	-

*Deaths per 1000 registered live births.

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e. Other Factors

(1). Alaska is not yet the point of sophistication to consider particular groups of mentally retarded individuals. The present availability of public and private community resources for the retarded and utilization of these is most apparent in Area Three - The Anchorage Area. It is felt that the Chart e(2), above titled "Relative Need" covers this consideration satisfactorily, though not precisely.

(2). Area Priority: Using the factors calculated in 1a-1d, the following ranks, sum of ranks, and final priority for the M.R. Facility Construction is determined. All factors are given the same weight.

Area Numbers & Name	Rank By Need in Numbers	Rank By Relative Need	Rank By Low Income Ratio	Rank By Per-Capita Income	Rank By School Yrs. Ratio	Rank By Infant Mortality Ratio	Sum of Ranks	Priority*
Bethel - 5	7	4	1	1	1	1	15	1
Nome - 7	6	1	2	2	2	2	15	2
Fairbanks - 6	2	3	5	5	5	3	23	3
Kodiak - 8	5	2	3	4	4	4	26	4
Ketchikan - 1	4	5	4	3	3	5	24	5
Anchorage - 3	1	6	6	7	6	4	28	6
Juneau - 2	3	7	7	6	7	7	37	7

*Ties are settled by awarding priority to the area having the greatest distribution of ratio skewed toward smaller values.

(3). Priorities Within Service Areas: Alaska is not yet in a position to establish priorities within services areas, particularly with the current situation of our low allotment, making any positioning disasterous; and our current lack of matching funds.

APPENDIX I

Characteristics of the Mentally Retarded:

Mental Retardation and mental illness are separate problems. Although the two problems are related in that they may on occasion occur in the same person and may involve some of the same kinds of professional skills in diagnosis and in the care of the individual involved, there are basic differences between them which necessitate the establishment of and adherance to different concepts and objectives in the planning process.

From a medical point of view, "mental retardation" is not a disease entity. It is a syndrome which can be produced by many causative agents acting singly or in combination. Symptomatically, it is characterized by subnormal intellectual function to an extent which prevents him from responding efficiently to the usual patterns of classroom instruction. From a social standpoint, the retarded child is slower in maturing and acquiring social and practical skills; as an adult, the retardate has less than the normally expected ability to manage his affairs and to progress and in gainful employment.

The currently accepted definition of mental retardation by the American Association on Mental Deficiency is "subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior". "Mental Retardation" thus encompasses a wide range of deviance, from minimal to profound. The distinction between normality and the mildest degree of mental retardation is arbitrarily defined. Mildly retarded persons are more comparable to those who are normal than they are to the most profoundly retarded.

Generally speaking, categories of services are established according to the practical level of functioning and age, rather than the cause of retardation. Nevertheless, etiology may have to be considered in the specifics of treatment or education for a particular individual. Practical distinctions must therefore be based on extent of impairment, taking account of the various factors which contribute to intellectual and social functioning. The manifestations of these levels of function change with age.

As stated above, mental retardation is defined as impairment of ability to learn and to adapt to the demands of society. These demands are not the same in every culture. Even within our own society they vary with the age of the individual. Society as a whole does little to assess the intellectual or social accomplishments of the preschool child. During the school years, however, the individual is evaluated very critically in terms of social and academic accomplishment. In later life, the intellectual inadequacy again may be less evident if social performance meets minimal demands.

The variation by age is to some extent determined by differential survival rates and other demographic factors. The very high prevalence at ages 10 to 14 is due primarily to the increased recognition of intellectual handicap of children within the school systems, while the

low number of infants from 0 - 1 year of age identified as retarded is in part attributable to the fact that their intellectual deficit is not yet apparent. Only gross impairment is evident in early childhood. Of striking significance is the fact that more than half of the individuals considered retarded during adolescence are no longer so identified in adulthood.

In view of these considerations, only gross estimates of the overall magnitude of the problem can be established. One such estimate may be derived through measures of intelligence. The numbers who are mentally retarded by this criterion can be calculated roughly on the basis of the experience with intelligence testing. Experience has shown that virtually all children with I.Q.'s below about 70 on most tests standardized nationally have significant difficulties in learning and in adapting adequately to their environment. About three percent of the school-age population score below this level.

APPENDIX II

STATUTES AND CODES

Excerpts from Health and Safety Code Title 18, Chapter 20, AS 1810
As Amended by Chapter 43 Laws of Alaska, 1958

SECTION 1 AMEND:

(1) Sec. AS 18.20.130 (1) to amended to read:

"hospital" means a place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment, or care for not less than 24 hours in a week of two or more unrelated individuals suffering from illness, disease, injury, or deformity, or a place devoted primarily to providing for not less than 24 hours a week of obstetrical or other medical or nursing care for two or more unrelated individuals and includes a convalescent home, nursing home, a public health center, and, as defined in sec. 210 of this chapter, a community mental health center and a facility for the mentally retarded.

(2) "federal act" means Title VI of the Public Health Service Act (42 U.S.C. 291 et seq.) concerning hospitals and medical facilities and the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (P.L. 88-164) concerning facilities for the mentally retarded and community mental health centers, both as now or hereafter amended;

(3) "facility for the mentally retarded" means a facility specially designed for the diagnosis, treatment, education, training, or custodial care of the mentally retarded, including facilities for training specialists and ahalitoral workshops for the mentally retarded, but only if such workshops are part of facilities which provide or will provide comprehensive services for the mentally retarded;

(4) "surgeon general" means the Surgeon General of the Public Health Service or any other federal agency designated to administer the federal act.

(5) "nonprofit facility for the mentally retarded" means a facility for the mentally retarded and a community mental health center which is owned and operated by one or more nonprofit corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual; and the term nonprofit private agency or organization which is such a corporation or association or which is owned and operated by one or more of such corporations or associations;

(6) "person" means any individual, firm, partnership, corporation, company, association, or joint stock association, and the legal successor thereof. (Title 47-4-1a ALLA, 1958);

(7) "governmental unit" means the State of Alaska, or any municipality, or other political subdivision, or any department, division, board, or other agency of any of the foregoing. (AS 18.20.130 (2)).

(8) "licensing agency" means the Department of Health and Welfare of the State of Alaska.

(9) "department" means the Department of Health and Welfare (AS 18.05.100 (3)).

(10) "commissioner" means the Commissioner of Health and Welfare (AS 18. .05.070).

Sec. 18.20.020 LICENSE. After September 1, 1947, no person or government unit, except the Government of the United States, acting severally or jointly with any other person or governmental unit shall establish, conduct, or maintain a hospital in the State of Alaska without a license under this law. (am L 1957, ch 112, Sec 3, p 146, app Mar. 28, 1957).

Sec. 18.20.030. APPLICATION AND FEES. An application for a license shall be made to the Licensing Agency upon forms provided by it, and shall contain such information as the Licensing Agency requires, which may include affirmative evidence of ability to comply with such reasonable standards, rules or regulations as are lawfully prescribed hereunder. Each application for license shall be accompanied by a license fee of ten dollars, and the Department of Health and Welfare shall cover all fees received into the State Treasury.

Sec. 18.20.040. ISSUANCE AND RENEWAL OF LICENSE AND POSTING. Upon receipt of an application for license and the license fee, the Licensing Agency shall issue a license if the applicant or hospital facilities meet the requirements established under this law. If the applicant or hospital facilities do not meet the requirements established under this law but continued efforts are made to comply with such requirements, then such applicant or hospital may be granted a temporary or provisional license for a reasonable period of time. A license, unless sooner suspended or revoked shall be renewable annually without charge upon filing by the licensee, and approval by the Licensing Agency, of an annual report upon such uniform dates and containing such information in such form as the Licensing Agency prescribes by regulation. Each license shall be issued only for the premises and persons or governmental units named in the application and shall not be transferable or assignable except with the written approval of the licensing agency. Licensing shall be posted in a conspicuous place on the licensed premises. (am L 1956, ch 112, sec 4, p 146 app Mar. 28, 1957)

Sec. 18.20.050. DENIAL, SUSPENSION OR REVOCATION OF LICENSE. The department may deny, suspend or revoke a license in a case in which it finds that there has been a substantial failure to comply with the requirements established under Sec. 60-90 of this chapter.

Sec. 18.20.060. RULES, REGULATIONS AND STANDARDS. The department shall adopt, amend, and enforce rules, regulations and standards for all hospitals designed to further the accomplishment of the purposes of Secs. 10-130 of this chapter in promoting safe and adequate treatment of individuals in hospitals in the interest of public health, safety and welfare.

Sec. 18.20.070. EFFECTIVE DATE OF REGULATIONS. TIME GIVEN FOR COMPLIANCE. Any hospital which is in operation at the time of promulgation of any applicable rules and regulations or minimum standards under this Act shall be given a reasonable time, under the particular circumstances not to exceed one year from the date of such promulgation, within which to comply with such rules and regulations and minimum standards.

Sec. 18.20.080. INSPECTION AND CONSULTATION FOR ALTERATIONS.
(a) The department shall make annual inspections and investigations of hospital facilities.
(b) The department may by regulation require that a licensee or applicant desiring to make a specified type of alteration or addition to its facilities or to construct new facilities shall, before commencing the alteration, addition or new construction, submit plans and specifications to the department for preliminary inspection and approval or recommendations with respect to compliance with its regulations and standards.

Sec. 18.20.090. INFORMATION CONFIDENTIAL. The department may not publicly disclose information received by it in a manner identifying an individual or hospital except in a proceeding involving the question of licensing.

Sec. 18.20.110. MISDEMEANOR TO ESTABLISH OR CONDUCT HOSPITAL WITHOUT LICENSE. Any person establishing, conducting, managing or operating any hospital without a license, under this law, shall be guilty of a misdemeanor, and upon conviction shall be fined not more than $100.00.

Sec. 18.20.120. INJUNCTION OR OTHER PROCESS TO PREVENT ESTABLISHMENT OR OPERATION WITHOUT A LICENSE. Upon the advice of the attorney general the department may maintain an action for injunction or other process against a person or governmental unit to restrain or prevent the establishment, conduct, management or operation of a hospital without a license.

RULE 4(C), ALASKA COURT PROCEDURES - RULES OF ADMINISTRATION (With Sept. 1968 Supplement)

JUDICIAL REVIEW. Any applicant or licensee or other person aggrieved by the decision of the licensing Agency after a hearing may, within 30 days after the mailing or serving of notice of the decision as provided by Section 6, file a notice of appeal to the District Court, and serve a copy of the notice of appeal upon the licensing agency. Thereupon the licensing agency shall promptly certify and file with the court a copy of the record and decision, including the transcript of the hearings on which the decision is based. Findings of fact by the licensing agency shall be conclusive unless substantially contrary to the weight of the evidence, but upon good cause shown the court may remand the case to the licensing agency to take further evidence, and the licensing agency may thereupon affirm, reverse, or modify the decision. The court may affirm, modify or reverse the decision of the licensing agency and either the applicant or licensee or the licensing agency or the State may apply for such further review as is provided by law. Pending final disposition of the matter, the status quo of the applicant or licensee shall be preserved, except as the court otherwise orders in the public interest.

APPENDIX III

PROGRESS MADE IN IMPLEMENTING ALASKA'S PLAN TO
COMBAT MENTAL RETARDATION

Since 1963 and the initiation of intensive planning and implementation of planning to combat mental retardation in Alaska much has been accomplished. Much more remains to be accomplished to meet the basic and special needs of the estimated 8,200 mentally retarded in our population. (See Table I in Appendix for breakdown of estimated functioning levels).

Progress has been largely the result of an increased understanding of mental retardation, the potential and needs of retarded individuals by the citizenry and the leadership in the state, aided by the provision of federal funds to add impetus to focused efforts. The following is a report on progress made in specific areas of planning.

COORDINATION

As some mental retardation will always exist, planning committees agreed that an Office of Mental Retardation need be created within the Department of Health and Welfare to provide a point of focus on the problem within state government and assist in the coordination of efforts of the departments, divisions, and branches within state government providing generic or special services to the mentally retarded, as well as those of federal and private agencies, to avoid duplication and promote the most economical use of resources.

It was further agreed that an advisory committee with membership representing unofficial agencies, organizations and the consumer should be established.

Legislation was introduced in the 1967 legislative session to create an Office of Mental Retardation and an advisory committee, which did not pass in that and the 1968 session. This is not considered to be a disaster, as the twice-amended bill, which originally was a poor piece of legislation, did not contain what was considered to be essential elements by the Governor's Advisory Committee, the consumer, and the administration. Provision was made by the 1968 legislature to carry out the purpose of the bill, following revocation of the federal grant, by allocating funds to the Department of Health and Welfare for an Office of Mental Retardation and an advisory committee.

Beginnings have been made in the coordination of service programs at the state and local levels. Departments, divisions, and branches have met and discussed mutual problems at the state level and have established communication. Community planning and coordinating committees have made gains in the development and coordination of comprehensive community services.

Comprehensive Health Planning has been initiated in the state, and a consumer of services for the retarded has been appointed to the planning committee. The Governor's Advisory Committee for Mental Retardation has offered technical service to the Comprehensive Health Planning Committee.

PREVENTION

Prevention programs are basic to any plan to combat mental retardation. It has been stated by a national authority that through the application of current knowledge 50% of mental retardation can be prevented.

We have been active in the area of prevention. The following accomplishments may each play a role in the prevention of mental retardation as well as other handicapping conditions.

The recommendations for the provision of family planning services to individuals requesting this service by the USPHS - Alaska Native Health, and the State Division of Public Health have been implemented. A Planned Parenthood Clinic has been established in Anchorage.

Legislation has been passed to create a register of disabilities, which was not funded. The register, when operative, will provide information concerning the disabled, including the mentally retarded, in need of services and location, thus providing much needed information for planning of specific preventive and ameliorative services in need of development, the location and amount of need.

The Division of Public Health has reimplemented the native midwife training and supervisory program through the reestablishment of the program in a northwest area of the state with a particularly high infant morbidity and mortality rate.

In 1967 the community of Bethel, with the assistance of the Office of Economic Opportunity funds, developed and operated a hospitality home for the care of high risk pregnant women from remote areas in need of prenatal and delivery services. Service was provided 196 women during the first year of operation.

The Department of Education has developed teaching units on sex, family living, marriage and nutrition, which have been incorporated into existing courses.

Legislation has been passed providing for the testing of newborns for metabolic conditions which may result in mental retardation.

Legislation passed in 1960 makes mandatory the reporting to state authorities of injuries to children caused by abuse, neglect or starvation.

National statistics reveal that of 6,000 children with encephalitis due to measles, 1,600 became mentally retarded. The immunization level in Alaska is high. 90% of our school children have received immunization for measles.

The programs of the community health clinics, USPHS - Alaska Native Health, and the Division of Public Health provide focus on programs to prevent handicapping conditions, particularly through prenatal and child care programs.

Programs for the economically deprived such as adult education, Head Start, job training, adequate housing, etc., are making small contributions to prevention, but funds available are too meager to provide the needed programs

to more than a few selected areas of need. A significant observation made by a staff member of Child Study Center was that of two children, with similar intellectual and physical endowment being evaluated, one having had the advantage of a village Head Start Program, the level of physical, social functioning, and use of intellect was markedly superior to that of the one who had not had the Head Start experience.

A pamphlet, Facts for Fathers about Fever, was published through the joint efforts of the Mental Retardation Project Office and the Division of Public Health.

CASE FINDING, DIAGNOSIS, AND TREATMENT

Early case finding of children not developing within normal limits permits evaluation and the early provision of a treatment or a developmental program to assist the child. Evaluation may be medical, psychological, social or psychiatric. Coordination of all areas of evaluation is usually needed. Research has revealed that the earlier the problem is defined and treatment instituted in the preschool years, the greater the opportunity to develop the existing potential for physical, social, emotional and intellectual growth. Early case finding, followed by evaluation and appropriate treatment, may prevent or ameliorate a large portion of mental retardation resulting from metabolic, neurological and sensory problems as well as those resulting from economic and cultural disadvantage.

Much attention has been focused on early case finding. Professional persons, private and public, providing services to children in Alaska, were sent letters interpreting the advantages to the child of early case finding evaluation and treatment.

Results of the effectiveness of the interpretation are not apparent in any increase in either applications for service nor increase in service to preschool children at the Child Study Center, a clinic providing an evaluative service for children throughout the state who are not developing within normal limits. Referrals at the six month through five year level remain few, with the majority of referrals falling in the five to nine year age group. The statistical reports from the Clinic show no increase in service, and it has been necessary to eliminate, at least temporarily, the itinerant clinic provided previously.

Effectiveness of interpretation to the private sector, physicians and agencies is not currently measurable.

Regional Mental Health Clinics, with the exception of the Anchorage Clinic, do not have all funded positions filled and provide limited service to the mentally retarded child and adult.

The Fairbanks Health Clinic, using funds allocated them for diagnosis of certain conditions in children, have shown initiative and ingenuity in the development of a child development clinic serving that area. The Clinic is patterned after the pediatrically oriented team approach used by the Child Study Center. The nursing staff provides the administrative, nursing and social aspects of the program. Private pediatricians periodically donate their lunch hour to the team staffing. The preschool class of the association

for the retarded provides observation and stimulation of children being evaluated, with the teacher a member of the evaluating team. The school or community agency involved with the child attend, contribute, and assist in the development of the treatment plan for the child.

Public Health nursing services are providing many necessary and basic services such as case finding, nursing assessments, referrals for appropriate services, and assistance to parents in home developmental programs. Interpretation to parents, teachers, and the community of the findings and recommendations of the clinical teams is usually requested of the public health nurse in rural areas, and her services may be needed in urban areas, where parents and agencies have direct contact, for interpretive and home program support.

In 1965 public health nurses made 501 visits to or on behalf of the mentally retarded. 631 visits were made in 1966. The figures for 1967 are not considered accurate, as a new method of accounting was instituted during this period and figures do not appear comparable.

The Division of Vocational Rehabilitation has provided services to approximately 160 mentally retarded during the past year. Team evaluation by staff and professional contact services, of the handicapped is provided to the teen-ager and adult as a basis for determining job training or other plan for the individual. The mentally retarded are provided service.

The Alaska Psychiatric Institute has included in-patient diagnosis and treatment for the mentally retarded in the recently revised plan of care and service for the mentally retarded.

The Alaska Crippled Children and Adults Treatment Center in Anchorage continues to provide diagnostic services in the psychological, speech and hearing, and physical development areas. Speech and hearing therapies, language development classes, preschool classes and physiotherapy may be provided. The educable mentally retarded are included in preschool and language development classes.

The USPHS - Alaska Native Health has established a mental hygiene clinic which provides some diagnostic services to mentally retarded beneficiaries within the hospital and those referred to itinerant clinics.

The Fairbanks Child Development Clinic and the USPHS Mental Hygiene Clinic services are new services provided in the past three years.

Psychologists and psychometrists employed by independent school districts are providing evaluative services for school children for school placement purposes. Anchorage, Fairbanks and Juneau schools provide this service. Kenai has funded a position which remains vacant.

COUNSELING SERVICES TO PARENTS AND RETARDATES

The understanding, acceptance, and security of parents in fulfilling the parental role in relation to an intellectually handicapped child is of vital importance to the parent, the child and society.

Parents, in general, react with strong feelings of inadequacy to the introduction of a retarded child into the family at the point at which parents become aware, consciously or unconsciously, of delayed development or mental retardation. Little assistance in understanding was possible in the past from professionals who themselves saw little potential or hope for children with less than normal intellectual endowment.

Society also placed a stigma upon mental retardation and the production of a retardate, as it was believed to be a genetic condition, transmitted by defective parental genes.

Medical research reveals that a very small proportion of mental retardation is genetically determined and that the cause of 50% of mental retardation cannot be defined with current knowledge.

Research also reveals intellectual development can be retarded by such factors as deprivation, lack of stimulation, malnutrition, neurological and sensory problems.

With new knowledge, society has withdrawn the stigma placed on the retarded child and his parents, but some of the old attitudes remain in instances in which the professional and citizens are not adequately informed.

A basic need of parents is for the acceptance of themselves as parents of a retardate and the acceptance of their child as a member of society, with the rights accorded other children and an opportunity to develop the potential for assumption of responsibility, however limited.

Counseling services readily available to parents and the retardate by persons with knowledge of new understandings, techniques, and resources can do much to provide understanding, acceptance, security, and to assist in the provision of the needed services for the development of the potential of the retardate.

Counseling services related to the specific problems of mental retardation by knowledgeable persons is not readily available in Alaska. Physicians, teachers, clergy, nurses, social workers, psychologists, vocational rehabilitation counselors, employment counselors, and parent members of associations for the retarded, may provide counseling services with varying degrees of understanding and competency. A continued search for realistic and appropriate solutions to problems may result.

Minimal counseling services to retardates and their parents are available through Regional Mental Health Clinics, Child Study Center, vocational rehabilitation offices, public health nurses, and the Mental Hygiene Clinic of USPHS - Alaska Native Health and schools. With the exception of the Child Study Center, the agencies and organizations have other than mental retardation as a primary concern.

RESEARCH

A study has been done by qualified psychologists concerning the need for the development of "valid" culture-free tests for use with our native population. The decision made, following study, was that adequate testing tools are avail-

ship. The problem is in the area of professional selection and use of appropriate tools.

The Arctic Health Research Laboratory is currently conducting a study of Alaskans with Down's Syndrome (mongolism). Chromosomal studies are being done as a portion of the research. A genetic clinic is being conducted at the Anchorage Borough Health Center with the cooperation of that agency and the regional Division of Health Office. Genetic evaluations, similar to those for Down's Syndrome, are conducted, and genetic counseling is provided when requested by the referring physician or health agency.

A study was done to determine need for a physician-attended prenatal clinic in the Anchorage area. Hospital admissions of obstetrical patients at two private hospitals and the USPHS Hospital were studied in relation to the trimester in which prenatal care was first received and payment for hospital services. A report based on 1966 obstetrical services at the USPHS Hospital which does not in general charge for prenatal and delivery services and hospital care to native beneficiaries, revealed that of the 270 obstetrical patients included in the study, 22.6% had not been seen in the prenatal clinic. 85% initiated visits in the third trimester.

479 cases were reviewed in the year study of one private hospital 76.6% received prenatal care in the first trimester, with all hospitalization paid, 19.3% in the second trimester, with 12.3% unpaid hospitalizations, and 5.9% in the third trimester, with 32.3% unpaid hospitalization.

A one month study of a second private hospital shows that of a total of 39 deliveries, 56.4% were seen in the third trimester. 28% were welfare patients. It was noticed that as the lateness of the first prenatal visit increased, so did factors such as illegitimate pregnancy and economic stress.

Presuming that early prenatal care is one of the effective ways of preventing complications that lead to mental retardation, this incomplete study indicates a need for an intensified educational program relative to the importance of early prenatal care and a prenatal, physician-attending clinic for the medically indigent not eligible for services at USPHS - Native Services Hospitals.

EDUCATION

The provision of special education for the handicapped, including the mentally retarded, has received priority attention in Alaska.

In 1965, when focus on planning for the mentally retarded was initiated, Alaska had passed mandatory legislation providing special education for the handicapped, including the educable and trainable mentally retarded of school age. Each year since the legislative action an appreciable number of independent school districts and state supervised schools have initiated special education program. (See Table II Appendix).

In 1964, on the basis of national percentages and Alaska's child population of 66,000, 1,650 educable retarded and 165 trainable retarded were estimated to be in need of special education services. A total of 378 Alaskan children were receiving special education service and this number included children with all handicapping conditions.

The 1967-68 records reveal that 367 educable and 62 trainable retardates were provided special educational services. We fall considerably short of meeting estimated need.

The following independent school district and state-operated schools have initiated special education - Anchorage, Fairbanks, Petersburg, Eielson Air Base, Ketchikan, Kodiak, Clarmalina, Metlakatla, Matanuska, Juneau, Kenai, Sitka, Nenana, Bethel, Nuiqsut, Bristol Bay, Ft. Yukon, and Haines-Port Chilkoot. Dillingham, Nome, Tanana, and the Valdez facility for the mentally retarded expect to initiate programs in the 1968-69 school year. The Alaska Psychiatric Institute has had a special education program for two years in cooperation with the Anchorage Independent School District.

The McLaughlin Youth Center will provide a special education program for residents under a similar plan to that at the Alaska Psychiatric Institute and the Valdez facility.

The provision of special education services to children in rural schools continues to lag behind need.

No special education for the retarded has, in the past, been provided in Alaskan Bureau of Indian Affairs operated schools. In school year 1968-69 two classes for the mentally retarded have been initiated in Kotzebue.

Children with special educational needs related to hearing handicaps and brain damage, from outlying areas, have been placed in the schools in Bethel and Anchorage, through cooperative agreements between the Bureau of Indian Affairs, the state, independent school districts, and parents. Others have been sent to schools in the lower 48.

A Special Education Consultant in the State Department of Education was added to staff in 1966. The Bureau of Indian Affairs created and filled a position for a Special Education Consultant in 1967.

While efforts to raise state allotments for special education students have not been effective (it costs on an average of two times as much to educate a special education student), allotments for all students have been raised. Policy has been established which provides transportation for special education students.

Anchorage has a successful work-study special education program at the secondary level, a joint Borough School District and Division of Vocational Rehabilitation project. Similar projects are planned for Juneau, Fairbanks, and Ketchikan. Kenai special education, without financial assistance, initiated such a program for two students.

Diplomas are granted special education students completing the special high school course.

Special education students are incorporated into appropriate regular classes and school activities in some schools, but the plan is not consistent. There is a tendency to isolate the mentally retarded.

VOCATIONAL TRAINING - WORK ACTIVITY CENTERS - EMPLOYMENT

With new knowledge and demonstration of the potential of the majority of the mentally retarded for gainful employment and independent or semi-independent living, vocational training for this group of handicapped persons has received increased attention. Federal funds have been allocated for planning and development of service in the broadened program of vocational rehabilitation, which includes the mentally retarded in job evaluation and job training program on a nationwide basis.

Federal agencies have provided leadership in the employment of the mentally retarded. Quality of job functioning rather than numbers is the criteria for hiring and retention. Nationally, 361 were reported as employed on December 31, 1966, and 2361 reported as the cumulative total by June 1, 1967. 79% of all retarded appointees were still on duty by June of 1967. 8 Alaskan retardates have been employed in positions in federal agencies. The majority of students completing the special education work-study program in the Anchorage Borough Schools have been gainfully employed.

Urban communities in Alaska are placing emphasis on the development of vocational training opportunities and employment of the handicapped, including the mentally retarded.

The Division of Vocational Rehabilitation has expanded staff and is providing leadership and the expertise in the development of community services for job evaluation and training leading to gainful employment of the handicapped. Associations for the retarded in urban areas have evidenced increasing interest in job training, work activity programs and employment.

Alaska has made progress toward meeting the needs of all handicapped in these areas.

The Division of Vocational Rehabilitation has received a federal grant for the purpose of evaluating vocational rehabilitation needs for the handicapped in Alaska and is assuming leadership in developing a plan to meet the needs. A survey of the state has been made in relation to needs, with results not yet available.

The Cook Inlet Rehabilitation Association in Anchorage has established two food handling centers for the training of the handicapped in food service. Mentally retarded persons have been included in the work sampling, evaluation and training programs provided. These resources may be used by the special education work-study project at the secondary school level.

The Anchorage Association for Retarded Children has made application for a project development grant through the Division of Vocational Rehabilitation to determine the direction their efforts should take to assit in providing services and facilities. The Fairbanks Rehabilitation Association has also made application for project funds, as has the Anchorage Association. All project applications have been approved at the state level.

The Fairbanks Rehabilitation Association has purchased a building which is used as a residence for those in job evaluation and training, with planning

to use a portion of the facility for job training. A food handling service is operated by the Association of the Arctic Health Research Laboratory cafeteria, which provides a training opportunity. Job training in other areas is planned.

The services provided by the private vocational rehabilitation agencies may be contracted for by the responsible public agencies and, in addition to job training, may provide room, board, and transportation to clients.

Ketchikan has developed a job-training program under the auspices of a community board which provides services primarily to the alcoholic. Residential facilities are provided. Consideration has been given to serving the mentally retarded, but considerable question has been raised as to the advisability of serving both handicaps in the same facilities.

We have no work activity centers providing long-term protected work programs. This is a particular concern of associations for the retarded, as a number of the mentally retarded can be productive but cannot function in competitive job placement. The Anchorage Association is particularly interested in the development of such a resource.

WELFARE SERVICES

The Division of Public Welfare provides generic services which contribute to early case finding and care of the mentally retarded, including assumption of certain financial obligations when the retardate or family meet eligibility requirements for financial aid programs.

Three years ago staff was so meager that case loads for the individual welfare worker far exceeded the standards set. Since that time there has been reorganization of the Division with new districts and offices created and staffed. Additional staff has been added to existing offices. With the growing population, case loads continue to be higher than standards permit and some areas of rapid development do not have readily available services.

New offices have been opened in Valdez, Kotzebue, Dillingham, Tanana, Kodiak, Barrow, Tok, and Ft. Yukon. The last five have workers who commute to work areas from district or regional offices, as adequate housing is not available.

Services which may be provided by the Division of Public Welfare to the mentally retarded are as follows:

Aid to dependent children to a parent or relative in behalf of a retarded child living in the home when other eligibility requirements are met.

Old age assistance to mental retardates living in the community who meet eligibility requirements.

Aid to the Disabled for adults if eligibility requirements are met. This program includes the mentally retarded, and payments may be made while in habilitative programs in the community if financial need exist and eligibility on the basis of disability is established.

Placement and payment for nursing home care if financial need exists.

Case finding and referral for evaluation with responsibility for following recommendations when responsibility is placed in the department.

Adoption placement and supervision.

Custody of a neglected or abused mentally retarded child may be assumed on court order, thus assuming the majority of parental responsibilities.

Foster home placement or supervision of children under custody and for those brought to urban areas for evaluation and medical care not needing hospitalization. Children may be placed in foster homes for special services not available in own community.

Responsibility for licensing and supervision of foster homes and group homes for children as well as licensing of child care institutions and centers.

Child welfare casework services and counseling services to parents and those caring for children.

The Bureau of Indian Affairs, a federal agency, provides child welfare and placement services for their beneficiaries in those instances in which the state does not have a program with federal support to meet the need. Placement in licensed foster homes or group homes may be made to provide special service for a handicapped child, including the mentally retarded, when the service needed is not available otherwise to the child. The agency assumes supervisory responsibility.

Living and training expenses for adults or young persons, including the mentally retarded, for vocational training are provided if need exists and funds are available.

Catholic Charities provide counseling to retardates and their families as well as possible financial assistance.

DAY CARE - DAY ACTIVITY - GROUP HOMES - FOSTER HOMES

The purpose of the above programs is to assist the mentally retarded, not in need of residential care, to live in their own home or community, to afford temporary relief to parents, to provide care during family emergencies, and to serve as developmental, habilitative and training resources.

Communities and agencies are working cooperatively to keep the mentally retarded in their own homes or the community through the development of special education and vocational programs, preschool programs, supportive public health nursing services, day activity programs for the teen-ager and young adult, foster care, recreational programs and the development of group homes for the teen-age and adult retardate.

Fairbanks and Anchorage have the only preschool programs for the mentally retarded within the state at this time. The Anchorage Retarded Children's Association provides preschool service to retarded children and includes retarded children not eligible for public school special education, without regard to age. The Alaska Crippled Children's Treatment Center provides a preschool program for the educable retarded, many having other handicaps for which treatment is received at the Center.

The Fairbanks Association for the Retarded preschool program has increased enrollment and will employ a second teacher for the 1968-69 program.

Within 1967 the Anchorage Retarded Children's Association initiated a day activity program for young adults and teen-agers not enrolled in the public school program nor employed. A particularly well qualified Vista Volunteer assumed responsibility for the successful demonstration of gains to be made through such a program. Young adults and teen-agers from the Alaska Psychiatric Institute were accepted into the program. Payment of tuition was waived. It is hoped this program may be continued.

The 1968 legislature appropriated $30,000 to be used by Association for the Retarded for preschool and day activity programs and $35,000 to the Alaska Crippled Children's Treatment Center.

Day Care Centers are in operation in Ketchikan and Fairbanks under the Office of Economic Opportunity. Mildly retarded children from the culturally and economically deprived population are accepted. Parent-Child Centers are anticipated for Nenana, Kotzebue and possibly Kodiak.

Efforts were made in 1966 and since to legislatively place responsibility within the Division of Public Welfare for licensing and supervision of group homes for the mentally retarded 16 years of age and over in need of such placement. This has not been accomplished. However, with the development of vocational training programs in residential care centers and in the community, the need is becoming more apparent and will increase. Active efforts have been made to stimulate private development of group homes with no concrete results to date.

RESIDENTIAL CARE

The concept of residential care is changing form that of a medical-custodial model to that of an education, training and habilitation model directed to the development of the greatest degree of independence possible, regardless of degree of mental retardation. This may involve training in self-care skills such as cleanliness, dressing and feeding oneself in a residential center, at one end of the spectrum, to job training and employment with independent or semi-independent living at the other.

We have learned through nationwide demonstration that the mentally retarded have far greater potential for the development of self-help skills, socialization, education, semi-independent and independent community living, vocational

training and employment through an understanding of the potential, special services needed and new techniques to meet special needs than formerly deemed possible.

The residential facility is no longer viewed as "the end of the road" for the mentally retarded, but rather as a facility housing varied programs for the development of the potentials in all areas of self-help skills and independence, a learning experience in living with man fellowman, at the highest possible level of independence.

Alaska's mentally retarded provided residential care at Morningside in Oregon, were returned to Alaska in 1967. As many as could be cared for by the staff available were placed in the Valdez facility, a 150 bed facility provided to replace the 50 bed facility destroyed by the earthquake and subsequent tidal wave. The facility is a satellite of the Alaska Psychiatric Institute. The remainder were provided care at Alaska Psychiatric Institute.

Qualified staff, with modern concepts of care, were employed for supervisory nursing positions at Valdez, and additional staff has been added, as available, and as housing resources permitted. An educational, training, and habilitation program has been instituted which is in line with modern concepts of residential care. An in-service training program is provided by supervising nursing staff. Staff employed in all professional, sub-professional and supporting services are provided in-service training relating their job function to the programs at the facility.

The employment and retention of nonprofessional staff for daily care was a constant problem. Review of the eligibility examination revealed that the examination ruled out, in general, many temporary hires with proven ability to provide quality daily care. A step forward was made when the Department of Administration revised the examination for nursing aides to permit the hiring and retention of appropriate staff. Solutions are being sought to provide low cost housing for staff needed to fill funded positions. Staffing remains a problem due to the isolation of the community, uncertainties of air and surface transportation due to weather conditions, the small community population from which to recruit, high cost of living, and unavailability of housing resources as related to salaries.

The Valdez facility has a population of approximately 90 residents. The space to accomodate the remaining 60 beds is being used for education, training, occupational and recreational programs for which space was not provided in the facility.

Program for the mentally retarded at the Alaska Psychiatric Institute has shown gratifying development under the current superintendent. The mentally retarded and the mentally ill have been separated except in those instances in which the retarded individual makes a better adjustment and progress with the mentally ill. Programs related to need have been instituted.

Current program has an education and habilitation focus. The Division of Vocational Rehabilitation and Alaska Psychiatric Institute has instituted a joint project that is essentially a vocational training project for the mentally retarded. There is free movement of residents between the Valdez facility and the Alaska Psychiatric Institute, with placement where the needs

of the resident can best be met through the programs provided. An in-service training program for staff is provided.

Such residential centers are making efforts to develop potentials for community living, with some on total financial independence. Those who will probably always require residential care are being taught to live with the greatest degree of independence possible in the setting.

While prevention and community programs to meet the special needs of the mentally retarded will decrease the percentage of retardes in need of this type of care, the need will continue and increase with the increasing population of the state.

Modern concepts of residential care have been instituted in all residential facilities providing services to Alaska's mentally retarded.

Alaska's severely retarded and multihandicapped children in residential care continue to be provided services outside the state at Haven Acres in Oregon, a private facility with which we contract for care. The children at Haven Acres are provided a training, educational, and habilitation program focused on the development of potential. It is believed that the majority of these children will require residential care during their life span. They are returned to Alaska when they reach the age limit specified by the facility or when developmental progress is such that they can be cared for in their own home, foster home or residential facility in Alaska.

In August 1968 Hope Cottage, a private group home for handicapped children in Anchorage, was granted a temporary license as an institution for children. Current enrollment is 10 children, the majority being mentally retarded and in special educational programs in the community.

Further expansion is planned, including the building of a cottage-type facility. This facility offers promise of developing, in time, a program that Alaska's handicapped children may be provided necessary residential care within the state.

RECREATION - RELIGION - SOCIAL GROUPS

Recreational programs for the mentally retarded have received increasing attention as they meet a basic need which is shared by all human beings. Recreational programs are of particular importance in the development of the mentally retarded who have, in large part, been excluded from the usual programs which do not meet the special needs of many.

Aside from meeting the basic need, other benefits of equal importance are derived such as socialization, physical development and coordination.

In the summer of 1967 the first recreational program for the handicapped in Alaska was initiated in Anchorage under the Parks and Recreation Program. Of the 25 children enrolled in the program, a majority were severely retarded. The program was continued in the summer of 1968 under the joint sponsorship of the City and the Anchorage Retarded Children's Association. Approximately

40 mentally retarded, out of the 52 children enrolled, were provided a summer recreational program.

Spiritual needs are met through regular church-sponsored programs from which the mentally retarded are not excluded. No special programs have been developed. The possibility of establishing a special religious program for the mentally retarded, nondenominational in character, is being explored in Anchorage. The clergy have provided counseling services to parents and the retarded, and have assisted in making appropriate referrals.

Current materials on the role of the church in relation to mental retardation have been widely distributed to the clergy.

Church-sponsored summer camps and programs have included the mentally retarded.

A Boy Scout unit for the mentally retarded has been organized in Anchorage. The Girl Scouts include some mentally retarded in their regular program.

Under the auspices of the Association for the Retarded, two teen-age groups were organized in Anchorage which provided recreational and social experiences for the mentally retarded. The groups are currently inactive due to transfer outside the state of leadership. Reactivation is planned.

Summer camping programs, under other than church sponsorship, are few, but have included a few selected mentally retarded.

Aside from the Boy Scout Troup, no special services are currently provided in the areas of social groups and religious nurture.

MANPOWER DEVELOPMENT

Alaska's need for manpower, with orientation to mental retardation, to staff generic and special programs serving the mentally retarded is great and is in line with national need for trained staff in special education and the helping services.

We have present disadvantage in the development and recruitment of staff, as neither of Alaska's universities have had an educational program for the training of professionals in the helping professions of social work, psychology, medicine, nursing, dentistry, etc.

Both universities have degree programs in education. Neither have had, in the regular curriculum, courses preparing teachers to meet the state eligibility requirements for special education teachers.

Progress has been made in the area of manpower development during the past three years, the result of the responsiveness of our universities to the needs within the state and the use of available orientation and training opportunities outside the state by professionals and sub-professionals serving the mentally retarded.

The University of Alaska provided seminars on special education in the summer of 1967 and 1968 for teachers to assist them in meeting eligibility

requirements. Special education courses are being included in the regular education curriculum of the universities for the coming year.

The 1968 legislature appropriated $50,000 to assist in the establishment of a School of Nursing at Alaska Methodist University. The program was initiated in the fall of 1968, thus establishing the first professional school in Alaska for the helping services.

Both universities are providing undergraduate training for sub-professional social workers.

The State Department of Administration is attempting to reclassify professional and sub-professional positions in the Department of Health and Welfare, to eliminate inequities and establish salary ranges which are more compatible with the responsibilities and background required by the position and to place the state in a more competitive position in acquiring staff.

Curriculum in the majority of professional schools for helping disciplines have provided little orientation to modern concepts and understanding of mental retardation and the new concepts and techniques to professional and sub-professional staff providing generic or special services to the retarded.

A handbook on mental retardation, published by the American Medical Association, was distributed to each physician within the state. Pertinent materials for other professionals have been provided.

A number of professional and sub-professional persons have been provided orientation to mental retardation through seminars in a federally supported educational vocational rehabilitiation project at the University of Oregon which includes this service to Alaska as a responsibility.

Nine professionals and citizens working with or interested in the mentally retarded attended a workshop on community planning for the mentally retarded at California State College Rehabilitation Training Center on Mental Retardation.

Orientation of professionals, individually or in groups, has been provided as requested through the Office of Mental Retardation.

Efforts have been initiated to provide training for sub-professionals and care persons through a short training course at Community College in Anchorage. As envisioned, such a course could be offered foster parents, group home operators, nursing aides, parents, and others caring for the retarded.

The possibility of inclusion of resource material on mental retardation at the Community College Library in Anchorage has been discussed with authorities, and has received tentative approval.

The Anchorage Association for the Retarded has started a library of materials on mental retardation for the use of parents and professionals.

In-service training programs are in effect at both residential facilities to upgrade care.

High school seniors have been advised of careers in mental retardation in an effort to stimulate students to obtain higher education in the helping professions. A number of college and high school students have requested materials on mental retardation for use on preparation of papers on the subject. These have been supplied.

Junior high and high school students have been stimulated to engage in volunteer activities by private and public agencies in an effort to stimulate an interest in obtaining further education in working with the mentally retarded or other handicapped persons.

PUBLIC AWARENESS

Individuals perceived to be mentally retarded by parents, the public and professionals, were considered to be hopeless and incapable of learning, developing skills, or providing for themselves totally or in some measure in the not too distant past. This attitude and lack of understanding has not been entirely dissipated in professionals and the citizenry.

The focus of general attention and beginning understanding of mental retardation in Alaska began in July 1957 with the initiation of the Child Study Center located in Anchorage, a Children's Bureau-supported clinic providing diagnostic service to children throughout the state suspected of mental retardation.

Itinerant clinics in other areas of the state helped to impart understanding and arouse the interest of the citizen and professional in those areas.

Parents in Anchorage, Fairbanks, Juneau, Ketchikan, and Kodiak organized Associations for the Mentally Retarded, assisting in educating the communities concerning the mentally retarded, their needs, potentials and in the development of community services.

Bethel, Palmer, Valdez, Barrow and Kenai have been added to the communities making efforts to form Associations in behalf of the retarded.

The involvement of communities and individuals in efforts under the planning and implementation project has, during the past three years, added considerably to public awareness.

Radio and television stations within Alaska have used materials on mental retardation provided by the National Advertising Council and have been generous in the provision of public service time to private organizations and public agencies.

PRIVATE ORGANIZATIONS

No presentation of the developments within the state would be complete without the inclusion of the development of Associations for the Retarded throughout the state, associations whose sole purpose is the education of the public concerning mental retardation and the development of services to meet the needs of those so handicapped.

In 1957, with the initiation of the Child Study Center in Anchorage, parents and community persons interested in the provision of services to the mentally retarded formed a group which later incorporated and affiliated with the National Association for Retarded Children. Fairbanks also organized and affiliated. Other associations have been or are in the process of organizing in Juneau, Ketchikan, Kodiak, Bethel, Palmer, Valdez and Kenai. Barrow has indicated interest.

The initial efforts of associations were focused on the provision of special education to the handicapped, including the educable and trainable mentally retarded.

Prior to enactment of legislation the Anchorage, Fairbanks, Kodiak and Juneau Associations provided classes for the preschooler and the retarded excluded from public schools.

Since passage of special educational legislation, Anchorage and Fairbanks Associations have directed their activities to the provision of classes for the preschool handicapped child and those excluded from the public school.

The Anchorage Association in 1968 provided a day activity program for the teen-age and young adult for whom no public educational training or rehabilitation program was available. Enrollment came from the community and Alaska Psychiatric Institute.

The organized groups have been effective in obtaining legislation with pozitive implications for the retarded, and have been instrumental in the initiation of special education in their schools. They have supplied speakers for other community organization meetings and school classes.

Volunteer services of young people have been solicited to assist in developing an understanding of mental retardation and stimulating the choice of a career in the helping services.

The state has entered into a "partnership" with private organizations through the provision of funds for teaching staff for the preschool programs for the handicapped of Associations for the Retarded and the Anchorage Crippled Children and Adults Treatment Center. Additional funds have been provided for other programs for the retarded sponsored by Associations for the Retarded.

APPENDIX IV

GUIDELINES TO THE FUTURE

Alaska has an unique opportunity in the development of programs to provide the needed services for the mentally retarded based on modern concepts of understanding, services needed, and techniques, in view of the fact that our programs are in the beginning stages. We need not duplicate errors made elsewhere. We also have an advantage in our energetic, progressive, innovative citizenry. Our generic services, provided by public and private agencies, are not so solidified that changes cannot be made to accommodate to the needs of the mentally retarded which are within the competency of the various agencies to meet. The willingness of Alaska to assist in the solution of problems for the less fortunate citizen has been demonstrated.

We have made strides in strengthening existing services and the creation of special services to meet special needs of individuals with intellectual handicap, as described in the previous section. Gaps in services and failure of existing services to meet the needs of a significant portion of our population exist. Gaps and needed extention of services will be discussed under appropriate headings, in format similar to the previous section.

Suggestions as to possible means of meeting needs are based on recommendations made by the Governor's Advisory Committee on Mental Retardation and consultants in the areas of child health, mental retardation, public information and residential care who have provided service to Alaska. Consultants have suggested possibilities, and have indicated willingness to assist the state with consultive services and efforts to obtain funding for expansion of existing programs and creation of quality programs to meet needs within Alaska.

COORDINATION

The Governor's Advisory Committee on Mental Retardation has recommended the creation of an Office of Mental Retardation within the Department of Health and Welfare and a Governor's Advisory Committee on Mental Retardation. The function of the Office of Mental Retardation is perceived as serving as a focal point within the state in matters pertaining to mental retardation and assisting in the coordination of state, federal and private services to avoid duplication and make the best use of funds available. Stimulation to strengthen generic services to the mentally retarded, assistance in the creation of new services to fill gaps, preparation of a public information program and consultation are also recommended functions of the office.

It was recommended that the Governor's Advisory Committee for Mental Retardation be composed of citizens who represent nonofficial organizations and associations interested in or providing needed services to the mentally retarded and that they be selected to provide for wide geographic coverage.

Legislation to accomplish the above has been recommended for the consideration of the 1969 legislature.

As noted previously, the Office of Mental Retardation and a Governor's Advisory Committee was funded by the 1968 legislature and is in operation.

Community committees for mental retardation need make special effort to include agencies, organizations and individuals interested in service and in the development and coordinated use of community resources.

The State Interagency Committee, in existence during the project, was for the purpose of coordinating the existing state services provided by three state departments. The committee discussed recommendations made by the Advisory Committee in relation to state programs and implemented some of the recommendations. Federal agency personnel were invited to meetings in instances in which dual services were provided the native segment of the population. Lines of communication on the subject of mental retardation were established between departments of the state providing services to the handicapped, with free exchange of information on agency function, problems, needs, and ideas for cooperative solutions in meeting needs. A similar committee, with modification, needs be continued to provide for free exchange of information in relation to developments and needs in state supervised programs, to assure coordinated services. No single state department, branch or division has the expertise nor authority to provide all services needed, i.e., preventive health services, diagnosis and evaluation, counseling, education, vocational training, employment, financial assistance, residential care, group home and foster care for the mentally retarded.

The needs of the mentally retarded must be considered by the Comprehensive Health Planning Committee. The Division of Public Health and Mental Health have programs relating directly to the generic and special needs of the mentally retarded, for which federal funding is available.

It has been recommended that an all-Alaska conference on human service policy and programs be held within the next two years with representation from administrative and direct service staff of state, federal and private agencies operating human service programs in Alaska. The goal of such a conference would be to develop a joint state-federal-private agency statement of human service purpose and policy in Alaska and to develop a set of general guidelines for such agencies in carrying out human service programs.

PREVENTION

Public Health programs which assist in the prevention of mental retardation and other handicapping conditions are well established in Alaska; however, we are not reaching the desired level of providing prevention services, particularly in rural areas.

In 1966 the U.S. rate of infant deaths was 23.4 deaths per 1,000 infants under one year of age. Alaska's infant mortality rate for the native infant was 52.5 deaths for 1,000 and 22.3 for non-native infants, the state rate being 37.2. The high rate of infant mortality among the native population continues despite the increased efforts of the State Division of Public Health, USPHS - Native Health Services, and the efforts of the private physician.

It is also to be noted that the native population for whom we are providing residential care is out of proportion to the percentage (20%) of the native in the total population, further pinpointing the sector of the population for whom intensified effort should be expended.

Studies throughout the states have revealed that in areas of economic deprivation the rate of mental retardation increases.

We now know that economic, cultural and social deprivation contribute to the problem of mental retardation.

Economic independence through adequate basic education, job training, job opportunities and adequate housing are necessary if preventive health services are to be utilized and effective. The study of obstetrical patients in Anchorage hospitals reveals that educational and economic need exists also in the urban area.

We have other problems in the provision of services due to immense geographical area, sparsely settled rural areas, increased cost of service, high cost of transportation to obtain or provide service, uncertainty of transportation due to climatic conditions in rural areas which can be reached only by bush plane, language and cultural barriers.

Efforts are being made to solve these problems. The solutions will require the continued, coordinated efforts of local, state and federal government and the total citizenry of the state. It would appear that methods of solving problems which have proven ineffective in the past should be replaced with innovative methods based on modern concepts.

Planned parenthood programs should receive continuing attention, with information, service and materials provided to all desiring the services.

Finding of the Register of Disabilities should be accomplished through the 1969 legislature to provide the necessary information for a sound basis for the development and location of preventive and ameliorative programs.

A high level of immunization for rubeola (measles) should be maintained throughout the state and for those diseases for which we have such preventive measures. Measles immunizations should be provided, as soon as consistent with sound pediatric practice, to all preschool children. New immunizations should be instituted, particularly for rubella (German measles), when immunization measures have been medically approved and are available.

Statewide educational programs on prenatal and child care should receive priority attention along with the development of prenatal, delivery, and pediatric services for the medically indigent. The mentally indigent native population has prenatal, delivery and pediatric service available. The problem is the delivery of the services in rural areas. These services are not, in general, available to the non-native medically indigent.

Physician-attended prenatal clinics should be made available to the non-native medically indigent in our population. The Anchorage Borough Health Clinic is considering a request to Children's Bureau for funding for such a clinic. Need has been defined.

The USPHS - Native Health Service, State Public Health Nurses and the Community Health Clinics provide educational services which have not accomplished the desired results as attested by infant mortality and morbidity studies. We

are in need of a coordinated program of education, planned and executed by the agencies involved and geared to the population to be reached. Innovative techniques and specially prepared materials need be developed.

The village medical aid program, instituted by the USPHS, should be expanded. Training of a community member and payment made for services could contribute much to the preventive programs.

Basic adult education, job training, employment opportunities, and adequate rural housing are of importance in the prevention of mental retardation resulting from economic deprivation.

Head Start Programs have proven value in providing stimulation to the deprived preschools child, elevating the health levels and have educational value to the parent as well. This program is in need of expansion.

Availability of funds and staff are important in achieving the long-range goals in prevention; however, we must engage in cooperative planning for attack on priority needs, using all resources available within communities and state, federal and local governments.

CASE FINDING - DIAGNOSIS - TREATMENT

Continued emphasis must be placed on early case finding followed by diagnosis and treatment, so that existing potential can be developed during the early years when learning patterns are initiated and when needed corrective medical and para medical services are most productive. Several of the most productive years, in terms of potential development, are lost when underdevelopment in any area is not perceived, diagnosed, and needed treatment instituted in the early formative years.

The resources for early case finding exist through private physicians, official and private agencies having contact with children, public health nurses and preschool programs.

Diagnostic services to children exhibiting delayed development in any area are in need of expansion. Two clinics currently are providing a team approach to diagnosis and planning, i.e., the Child Study Center in Anchorage and the Child Development Center in Fairbanks.

Children's Bureau Consultants have expressed interest in and willingness to consider financing the expansion of both programs.

Financing for additional staff for the operation of the Fairbanks Clinic might be considered to provide administrative services, social services, nursing services, consultive medical services not available in the community, and payment for the conference time of professionals. Initially, the clinic could provide service to the Fairbanks area, with later expansion to serve the Northern Region.

The Child Study Center might well consider reinstituting itinerant clinics to communities and the addition of a public health nurse and second social worker to staff. The function of the public health nurse could include an educational function to nurses in the nursing assessment of a child, and instruction in new

techniques in home care and management of the handicapped child to nurses, parents and community persons. The addition of a second social worker would permit expansion of the program to include counseling and group therapy to parents in need of these services, as well as social casework treatment to the retarded.

The establishment of a similar clinic to serve the southeastern area of the state should be given consideration.

Private resources, the Division of Vocational Rehabilitation, and understaffed Regional Mental Health Clinics are the only resource available to the adult retardate living in the community for diagnosis, planning and counseling. Mental Health Clinics perceive their function as being primarily related to emotional disturbance, and background training has been in this area rather than that of mental retardation.

As rehabilitative and care services for the mentally retarded living in the community are instituted, the need for coordinated, comprehensive evaluation and team planning for teen-agers and adults, as well as children, is becoming more apparent. Consideration should be given to strengthening and publicizing of the evaluative services of the Division of Vocational Rehabilitation for the teen-ager and young adult.

While a number of the adult mentally retarded can live in the community and be completely or partially self-supporting, most are in need of counseling services at times of crisis and/or change. Such services are not readily available and will become more apparent as the development of community services permits community rather than residential living for an increasing number of this handicapped group.

Generic public agencies provide counseling services for their clients in the area in which they provide service. They may or may not be aware of services, counseling, job training, health and other services that may be provided concurrently. The retarded individual may not be aware nor able to inform of other services provided, hence, a coordinated agency approach need be developed to meet the needs.

Physiotherapy, and speech and hearing therapies must be coordinated with other planning for the mentally retarded in such a way that the best use of limited therapeutic time is made.

Consultation and supervision by specialists need be sought to enable the home or agency to provide therapies to children for whom individual treatment by the specialists is not available nor feasible.

EDUCATION

The majority of our larger population centers have instituted special education programs for the handicapped, including the mentally retarded. Special education services to the mentally retarded in rural areas are few but are steadily developing. While provision has been made for special education services to a few children with brain damage and hearing handicaps

outside their home communities, such planning for retarded children in rural areas with other than these handicaps has not been effected.

The mentally retarded, if not disruptive in the regular classroom, are included in the rural school program. The student-pupil ratio, number of grades taught by the teachers, and level of teacher competency in providing special education, makes individual attention to the needs of the mentally retarded nearly impossible; hense, a retardate may spend his time in the classroom with little assistance in developing potential. He may make gains in socialization, but special educational and training needs cannot be met in this situation.

We must find ways of meeting the needs of the mentally retarded, preferably in the community of residence. Consideration should be given to the provision of additional staff where the need warrants. Consultation and demonstration in rural schools may be a possible means of strengthening service.

It has been said that education in rural schools is all special education, and this may well be true, as it is in the rural areas that we find economic, cultural and social deprivation which we are aware are contributing factors to subnormal functioning in the prevailing culture.

We are far from the solution of providing adequate special educational services to children in our rural communities, essential for development toward independent or semi-independent living as adults. For many of the mentally retarded from rural areas, as in the past, residential care will be necessary when families are not able to assume responsibility.

Bureau of Indian Affairs and state educational administrators need to continue working together for solutions to the joint responsibility of providing appropriate educational services to Alaska's rural children.

Secondary school work-study programs are in need of expansion for the continuing education of the handicapped and especially the mentally retarded, as the ability to achieve adult independence will depend upon selective work-training rather than academic achievements.

Preschool programs for the handicapped and culturally-deprived provided through Associations for the Retarded, the Crippled Children and Adults Treatment Center and Head Start have been effective. The expansion of preschool programs to deprived areas, not receiving these services, should be effected.

VOCATIONAL REHABILITATION - WORK ACTIVITY CENTERS - EMPLOYMENT

The ability of the majority of the mentally retarded to utilize job training services and to become partially or full self-supporting has been demonstrated throughout the nation and in Alaska.

Impetus has been provided through federal funding to survey the needs of the handicapped for training in job skills and to develop a state plan to meet the needs. The needs of the mentally retarded are included.

Work activity centers for job evaluation and training are few, are located primarily in Anchorage and Fairbanks, and are limited in scope. Such centers are needed in other population areas throughout the state to increase service available and provide for training in a greater diversity of skills.

Work activity centers provide for a diversity of services, from job evaluation and training to assistance in obtaining employment in competitive industry and long-term work activity for those unable to function in unprotected, competitive employment.

Employment possibilities in Alaska for the handicapped, including the mentally retarded in rural urban areas, need be surveyed and programs developed to train in the necessary skills, work habits and attitudes for either competitive or protected employment.

The cooperation of labor, business and the public in the state must be obtained through education and demonstration of the employment potential of the handicapped and the contribution they can make to society.

The coordinated, cooperative use of federal, state and private resources, based on the defined needs within the state, are needed in the development of appropriate vocational rehabilitation programs. The results will be "income producing" rather than "income using" handicapped individuals with a sense of human dignity in a culture that places great value on economic and personal independence.

WELFARE SERVICES

Welfare services are directed primarily to individuals living within the community or in facilities licensed by the Department of Public Welfare and in need of child welfare or financial assistance programs. Mental retardation may be the cause of need for a particular type of assistance. Individuals are not necessarily labeled as mentally retarded but rather as recipients of the services provided.

Few professionals and subprofessionals have had orientation to mental retardation in their academic training, although the majority of employees in service agencies are in frequet contact with the mentally retarded.

It has been recommended that a consultant in mental retardation be employed by the Division of Public Welfare. We have service resources within the Division to provide partially federally funded services to the mentally retarded which can assist in developing potentials for community living, independent or semi-independent, of benefit to the individual and at a cost to the state which is far less than that of ultimate residential care.

The foster home care program for children coming into the Anchorage are for medical evaluation is well developed and provides this service to those in need of it for evaluation at the Child Study Center and other clinics. Thought should be given to this need should clinics be developed in Fairbanks and Southeastern to serve those areas.

A totally unmet need is for group homes for the mentally retarded 16 years of age and over who are capable of living in the community and for whom residential care is the only alternative.

This will be discussed at length under the section including group homes. It is mentioned here as it appears imperative that group homes be developed and that they be licensed and supervised by the Division of Public Welfare for the mentally retarded over 16 years of age. The need for supervision and assistance in the problems of the daily community living is much the same for the adult mental retardates as for children.

DAY CARE - DAY ACTIVITY - GROUP HOMES - FOSTER HOMES

Day care programs which are designed for the mentally retarded, or which include other than the mildly retarded, are not developed to any degree in Alaska. The service is provided in Fairbanks and Anchorage only. The two day care programs are developmental in nature, with primary focus on the preparation of the retarded preschool child for special education and as a resource for further development of the school age child not ready for or excluded from the public school. Secondary gains are respite for parents.

With the numbers of mentally retarded children enrolled each year in the first year of schooling it would appear that we have not met the need of the mentally retarded for developmental preschool experiences. This is an area that could well be explored by Associations for the Retarded and if need exists in the community, programs established.

Day activity programs for the mentally retarded teen-ager and adult who is no longer in school or is unemployed and living in the community, is a much needed program.

The Association for Retarded Children of Anchorage provided such a program in the winter of 1968 which was under the supervision of a Vista Volunteer. Continuation of this program is planned when appropriate staff is obtained. Such a program provides for the development of socialization and recreational skills for the retardate, grooming and self-care skills, creative expression through arts and crafts and, dependent upon the competency of the supervisor, further development of academic skills related to everyday living. We have retardates, late teen-ager and adult living in the communities, who have not had the advantage of special education ,socialization, recreational experiences, training in self-help skills, and the development of household skills. The program provided has demonstrated that potential has not been completely lost, and skills for a useful, successful home and community life can be developed.

The exploration of need by communities and the development of day activity programs to meet the need can provide constructive use of time which otherwise may be used in antisocial and destructive activities in the home and community. An increase in the adequacy of the individuals in daily living within the family and community can result.

The need for licensed, supervised group homes for the mentally retarded 16 years of age and over has been mentioned previously, as was the increasing awareness of need. The change in focus in our residential care program from medical-custodial

to training, education and habilitation, and the vocational-rehabilitation project for the mentally retarded at Alaska Psychiatric Institute, has brought this need into focus. Supervised living facilities will be needed for the greater portion of the vocationally trained who have no homes, or are unable to find work suitable for their acquired job skills in the home community. This applies also to retarded teen-agers and adults not in residential care, being evaluated and provided training by the Office of Vocational Rehabilitation.

Supervised living will be needed not only for those partially or fully self-supporting, but for those in job training or work activity programs unable to live in own home.

It has been recommended by the Governor's Advisory Committee for Mental Retardation that legislation be enacted which places the responsibility for the licensing and supervision of group homes for the mentally retarded, 16 years and over, in the Department of Public Welfare. The State Interagency Committee recommended that "handicapped" replace "mentally retarded" and this was approved by the Governor's Advisory Committee.

We feel group homes should be developed under,private auspices, with consultation provided by pertinent agency staff.

Payment for service may be from the earnings of the residents, the agency of agencies involved, parents or estate and, if eligible, disability payments. The estimated cost of group home living is approximately $200.00 per month, considerably less than the approximate cost of $930.00 a month at Alaska Psychiatric Institute or the slightly lesser cost at the Valdez facility.

Federal matching funds are available for construction of facilities for the mentally retarded and for staffing to official or nonprofit organizations for program initiation or expansion. The use of these funds for this purpose could be considered by the private sector.

Foster homes for mentally retarded children, as well as children with other handicaps, in need of special education and other services not available in their home communities, are in need of development. Should Fairbanks and Juneau initiate Child Development Clinics to serve the regions in which they are located, such facilities will need be an integral part of planning for the delivery of services to children outside these urban areas.

Group homes for mentally retarded children should be developed when foster care resources cannot meet the need. Private organizations and individuals interested in the mentally retarded should consider the development of such care facilities for children in population areas having community medical and educational services available.

Foster homes for adult retardates have not been developed in Alaska. This is a possibility which should not be overlooked, as individual adult retardates can well fit into family living and be competent contributors to family life and activities.

The Governor's Advisory Committee studied the question of protective services for the mentally retarded adults living in the community but who were incapable of making decisions on important matters. It was recommended that the

subject be researched and legislation drafted to provide for general and specific guardianship services to meet this need.

RESIDENTIAL CARE

As stated previously, focus of residential care programs for Alaska has changed in the past two years from a medical-custodial focus to one of training, education and habilitation, based on new knowledge and demonstration of its values. Special educational programs are available to the mentally retarded in all residential centers to those ready for this service. Development of self-help skills and the greatest degree of independence is stressed.

The Valdez facility, built to provide residential care to 150 mentally retarded was constructed upon the old concept of medical-custodial care. Pleasant and adequate sleeping and eating space was provided for this number. A large center rotunda was provided for activity, or seating space for inactivity.

No space was provided for active indoor winter recreational activities, vocational rehabilitation pursuits, arts and crafts, nor special education, a necessity when tranquilization is withdrawn to the extent that residents or students, if you will, have enough awareness of their environment to utilize programs for the development of their potential.

Consideration was not given to space for age grouping. Programs for the young and elderly differ and active youngsters may be a constant irritant to elderly retardates.

Lack of space for programs, as well as lack of staff to care for 150 residents, has resulted in the conversion of space planned for sleeping to use for the steadily developing program. Partitioning of the rotunda has provided space for programs for the younger retardates. Unused sleeping space has been converted to provide space for special education and arts and crafts.

In order to operate to capacity and continue the developmental program, space for a winter indoor activity program is needed. This has been requested as a separate, connected building to include a half gym and space for occupational therapy and special education. The total bed capacity can be made available with the provision of needed space for program and the recruitment of additional staff.

A Federal Hospital Improvement Grant (non-matching funds) can be made available to the Valdez facility for the expansion of a current program on the addition of a new program designed to enhance the care given. The facility is eligible as it is no longer a satellite of the Alaska Psychiatric Institute.

Separation of the Two facilities, was accomplished in June of 1969.

Automomy for the Valdez facility had been recommended by the Governor's Advisory Committee for Mental Retardation, consultants from the President's Committee for Mental Retardation, and consultants from the Division of Mental Retardation, Region IX.

tion staff attached to the improvement program can be funded. Possible suggestions are the addition of an occupational therapy program, with employment of a qualified occupational therapist, a full-time social worker, and an individual to coordinate and schedule the activities of each resident in the various programs needed for the development of potential.

Research has noted that leadership in the program aspects of successful residential center for the mentally retarded need not be a physician. Other professional persons, with training and experience in residential care of the retarded can be equally, or more effective. Individuals with experience and an educational background in nursing, education and vocational rehabilitation have been successful in the administration of modern residential care programs.

Hope Cottage, operated by a private non-profit corporation in Anchorage, has been licensed by the Division of Public Welfare as a children's institution for the care of physically and intellectually handicapped children. Children from 3 to 18 are provided care. Current population is 18, the majority being mentally retarded. Two cottages are in operation and planning is in progress for further services and additional cottages.

The development of this facility has implications for the retention of multi-handicapped, severely and profoundly retarded children in Alaska. The Hope Cottage administration and board dreams of being able to develop all the services provided our children in Oregon.

It is interesting that the researchers studying the medical-custodial and the social-educational-habilitation models of residential care suggested that "probably" the medical model for the profoundly and severely retarded would always be needed. Our experience with Haven Home in Oregon would raise question concerning this, as program is based on the latter model, with medical need met by the contractual services of a pediatric consultant. Consultants from other disciplines are used as need arises.

The Governor's Advisory Committee for Mental Retardation has recommended that Alaska's children be returned to Alaska and has set ten years as the maximum target time.

With the possibility of providing residential care to the profoundly and severely retarded and the multi-handicapped children in Alaska, and the transfer of children from Oregon back to Alaska as the programs at Valdez and possibly Hope Cottage develop to meet our needs, the goal seems possible.

The Governor's Advisory Committee for Mental Retardation has recommended that no consideration be given to an increase in bed capacity at the Valdez facility. The isolation of the community, uncertain transportation, lack of community services, and difficulty in obtaining staff, contributed to the recommendation.

With expected population increase, the number of the mentally retarded will increase despite intensified preventive measures which should decrease rate. Should additional facilities for residential care be needed, construction of another facility should be given consideration.

Factors to be considered in determining location are accessibility, central location, availability of social medical and para medical services in the community, other professional services, and the educational programme of our universities for courses in the helping professions which provide services to the mentally retarded.

An appropriately located residential centre could contribute to prevention and amelioration programs for the mentally retarded, through training in the care of the retarded, as the facility program could be used as a laboratory experience for students in nursing, practical nursing, social services, counselling and other professional and sub-professional educational programs.

RECREATION - BOWLING LEAGUES

Recreational programs for the mentally retarded children and adults living in the community need to given further consideration. Those who are capable of participating in established programs should be included, and special programs should be planned for those with special needs. Skating, swimming, ball playing, and bowling are among the recreational activities that assist in the development of the mentally retarded and the ability of the retardate to participate and enjoy these activities has been demonstrated.

Inclusion in summer camp programs for socialization, recreational and, in church-sponsored camps, spiritual values.

Six programs of religious nurture, specifically planned to meet the needs of the mentally retarded, have been developed in Alberta. A number of our mentally retarded are incorporated into the regular church groups, and this is preferable where possible. Consideration is currently being given to the development of a Junior School class designed to meet the special needs of the retardates by two Anglican church groups.

Boy Scout, Girl Scout, 4H and other such youth programs are activities in which the mentally retarded have shown an ability to accomplish the goals and from which they gain considerable confidence. The Boy Scouts have prepared a manual specifically for the mentally retarded. The development of such groups throughout Alberta should present a challenge to leadership in these areas of activity.

MANPOWER DEVELOPMENT

National looks in the availability of manpower for the helping services has resulted in a close scrutiny of the use of professional personnel and the most advantageous uses to be made of sub-professionals and aides.

Job functions traditionally performed by professionals have been broken down to the component parts of professional and semi-professional activities. Total use of sub-professionals and aides for portions of jobs, but professional in nature, under professional supervision has proven effective. Inservice training programs and universities and community colleges are training young people to successfully perform defined functions which were previously only within the scope of the professional. In relation to the mentally retarded, innovations in staffing patterns for parental services, day care, residential centres and other services show that sub-professionals, under the supervision of or with consultation from the professional, can

provide an adequate service with effective results. The training and hiring of the mildly retarded for supervised daily care of more severely retarded has produced gratifying results for the employed and those cared for.

The use of teacher's aides under teacher supervision in the schoolroom has proven of value in release of teacher time for purely professional activities.

Alaska is training and hiring sub-professionals for service in the helping professions. However, many positions remain unfilled, primarily at the professional level, for psychiatrists, nurses, social workers, clinical psychologists, etc. Professional training has been initiated for nurses.

Training for professional social workers and clinical psychologists is needed, as well as a full academic program to train special education teachers.

Orientation to mental retardation and the new techniques and goals of care need be provided the professionals who have had little background in mental retardation in academic curricula. In-service training programs continued use of the services of the University of Oregon, inclusion of the information at professional meetings, are means of assisting in the solution of the problem.

Prevention of mental retardation and other handicapping conditions through early case finding programs may be strengthened by an increased awareness on the part of public health nurses and early referral for services available. A nursing conference on child development and nursing assessment has been suggested as a possibility. It has been eight years since a similar nursing conference was held, during which time we have had a great turnover in staff. Children's Bureau Consultants and the Chief of the Branch of Nursing have expressed an interest in such a conference. Children's Bureau financing is possible.

The young people of Alaska are in need of stimulation to pursue further education, sub-professional or professional, to meet our continuing needs for staffing the helping services that provide services to the mentally retarded. They need be made aware of careers available in service to the mentally retarded and the handicapped in the areas of medicine, dentistry, nursing, psychology, social work, speech and hearing, vocational rehabilitation and physiotherapy.

The use of youth volunteers in programs for the mentally retarded has proven effective in stimulating the choice of a career related to the retarded and such volunteer activities are in need of further stimulation.

PUBLIC AWARENESS

Public education must be a continuing process in both urban and rural areas to keep the general public informed of advances in our understanding of mental retardation, effective prevention measures and treatment, and resources available.

It is through the understanding of the general public as well as the professional that stigma related to the condition will be removed and appropriate

programs for prevention and the development of potential will be developed and supported.

It is no accident that urban communities, in which those interested in solving the problem of mental retardation used all information media available, have developed special programs for the mentally retarded and have reached enough of the public to result in legislation of benefit to the retarded.

In remote rural areas, where great need exists for understanding, preventive programs and the use of resources available, much of an educational nature needs to be done.

A special educational program should be developed for radio transmission, in easily understood language. This should consist of short, two or three minute briefs, each making but one point. Focus could here be on prenatal, delivery, child development and care topics. Resources and directions for obtaining the services should be explained.

The materials prepared for the radio could be easily adapted to television and other news media as well as developed in pamphlet form.

Such an educational program should be prepared jointly by the state and federal agencies involved and with consultation from information dissemination specialists connected with public information media in the state.

The public information specialists with the President's Committee on Mental Retardation recommended, following a consultive visit to the state, that the several radio communication systems operating in Alaska be studied to discover whether and how education services for persons living in remote areas might be conducted via one or more of the systems.

It was further recommended that a small expert advisory committee be formed to assist the Office of Mental Retardation develop public information and education materials and presentations on mental retardation.

If we are to be successful in combating mental retardation in rural as well as urban areas, citizens must have the necessary information and services must be available for prevention, treatment, and development of potential. The resources must be known by the public as well as the professional. A directory of resources, generic and special, available to the mentally retarded within the state should be prepared and given state-wide distribution. Public education must be a continuing process even in urban areas.